

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D MAY 24 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

16435

Do not use this space.

1. PLACE OF DEATH

(a) County Wright Registration District No. 908
(b) Township Mountain Grove Primary Registration District No. 4549
(c) City Mountain Grove (d) Street No. 13
(e) Length of residence in city or town where death occurred 50 yrs. 7 mos. 7 ds. (If death occurred in Hospital or Institution, write its name instead of street and number)
(f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Lizzie Frances Allen St. Mo.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jessie Wilcox Allen
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 28, 1866
7. AGE YEARS 72 MONTHS 8 DAYS 2 IF LESS than 1 day, hrs. min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) West Plains, Mo.
(STATE OR COUNTRY)

13. NAME William D. Mustang
14. BIRTHPLACE (CITY OR TOWN) Tenn.
(STATE OR COUNTRY)

15. MAIDEN NAME Jane Langston
16. BIRTHPLACE (CITY OR TOWN) Green, Missouri
(STATE OR COUNTRY)

17. INFORMANT Bernice Allen
(ADDRESS) 321 N. Duver St. Green, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE West Plains DATE March 12, 1939

19. FUNERAL DIRECTOR (NAME) George Slaps
(ADDRESS) Mountain Grove, Mo.

20. FILED 4-10-1939 Bernice Mustang
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 10, 1939

22. I HEREBY CERTIFY That I attended deceased from August 1938 to Mar 7, 1939

I last saw her alive on Mar 7, 1939 Death is said

to have occurred on the date stated above, at 4:15 A. M.

The principal cause of death and related causes of importance were as follows:

Coronary Occlusion
946

Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) W. R. Craig M. D.

(Address) Mountain Grove, Mo.

RECEIVED

District Health Officer No. 6,

District File Number 6-5-39-1034

Date Filed MAY 8 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by

Registered Apprentice No., working under my personal supervision.

Signed

Licensed Embalmer No. 3161

P. O. Address Mt. Grove, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.