WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

FILED MAR 12 1940

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

6210
Do not use this space.

1. PLACE OF DEATH
(a) County Cape Girardeau — Registration District No. 124
(b) Township Hinder — Primary Registration District No. 5777 — Registered No. 10
(c) City .... (d) Street No. .... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred .... yrs. .... mos. .... ds. (f) How long in U. S., if of foreign birth? .... yrs. .... mos. .... ds.

2. PRINT FULL NAME 450 Elizabeth Allen
(a) Residence, No. 0 .... St.
(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 (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: George Allen
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Aug 15-1858
7. AGE: YEARS 81 — MONTHS 6 — DAYS 5 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Housekeeper
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): Feb 1-1940
11. Total time (years) spent in this occupation: 60 y

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Burfordville, Mo.

FATHER
13. NAME: Porter Berry
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Burfordville, Mo.

MOTHER
15. MAIDEN NAME: Nancy Allen
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Burfordville, Mo.

17. INFORMANT: Chester Allen
(ADDRESS): Burfordville, Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Allen Cemetery — DATE: Feb 22-40

19. FUNERAL DIRECTOR (NAME): Crocroft Miller
(ADDRESS): Jackson, Mo.

20. FILED 2-20, 1940 D. E. Seibus — Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Feb. 20, 1940

22. I HEREBY CERTIFY, That I attended deceased from ...., 19...., to ...., 19....

I last saw h.... alive on ...., 19...., Death is said to have occurred on the date stated above, at 2:15 p.m.

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

I E. R. Prickett coroner of Cape County after having the evidence given in the case find that the deceased Elizabeth Allen came to her death of a natural cause.

Date of onset

Other contributory causes of importance:

700 B

Name of operation .... Date of ....
What test confirmed diagnosis? .... Was there an autopsy? No

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) E. R. Prickett Coroner, M.D.
(Address) .... Cape Girardeau

Licensed Embalmer's Statement on Reverse Side)

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.....

P. O. Address.....

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.

. No. 2B
—2-21-40
I X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6210

Registration District No. 124 Primary Registration District No. 5122 Registrar's No. 10

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) ~~City or town~~ Kinder Twp

(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Elizabeth Allen

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 20 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

8. AGE: Years	Months	Days	If less than one day: hr. min.
81	6	21	

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER 12. Name

FATHER 13. Birthplace (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name

MOTHER 15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 2-26-40 (Date received local registrar) (b) D. G. Seibert (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature E. R. Tuckey (M. D. or other)

Address Cape Gir Date signed 2-26-40

SUPPLEMENTARY