

FILED MAR 7 - 1940  
566

Registration District No. 566

Primary Registration District No. 3030

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Mississippi  
(b) City or town Charleston  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Rittie Ann Allen

3. (b) If veteran, name war X X X 3. (c) Social Security No. X X X

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Charles W. Allen 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased Nov. 30 1891  
(Month) (Day) (Year)

8. AGE: Years 48 Months 2 Days 23 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business At home

MOTHER FATHER  
12. Name James F. Griffin  
13. Birthplace not known Arkansas  
(City, town, or county) (State or foreign country)  
14. Maiden name Harriet I. Stacy  
15. Birthplace not known Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Adeline Perkins  
(b) Address Providence, Kentucky

17. (a) Burial (b) Date thereof 2-25-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Oak Grove Charleston

18. (a) Signature of funeral director John P. Munnally  
(b) Address Charleston, Mo. 745

19. (a) 2-27-40 (b) J. S. Deman  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi  
(c) City or town Charleston  
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 23rd.  
year 1940 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from Feb 19  
1940, to Feb 23, 1940;

that I last saw her alive on Feb 23, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Unemia Duration 3 days

Due to Acute nephritis 1 week

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations: 131  
Of autopsy: \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature Paul S. Baur (M. D. or other) \_\_\_\_\_  
Address Charleston Mo Date signed \_\_\_\_\_

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

120

RECEIVED

District Health Officer No. 2

District File Number 340-66

Date Filed 2/5/40

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 *John F. Nussle Jr*

Licensed Embalmer No. 3851

P. O. Address *Charleston 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 7412  
Registrar's No. 27

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 566

Primary Registration District No. 3030

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

1. PLACE OF DEATH:  
(a) County Mississippi  
(b) City or town Charleston  
(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  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME Pattie Ann 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)

8. AGE: Years Months Days If less than one day  
48 2 23 h min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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.....

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.

20. DATE OF DEATH: Month Feb day 23 year 1940 hour..... minute..... M.

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

Immediate cause of death Acute nephritis

Due to Chronic nephritis

Other conditions 131

Major findings: Of operations..... Of autopsy.....

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?.....  
While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature Paul S. Sawyer (M. D. or other) Address Charleston, Mo. Date signed.....

Duration  
5 yrs.  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

