

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.

1940

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

26497

Do not use this space.

## 1. PLACE OF DEATH

(a) County Sullivan  
(b) Township Taylor  
(c) City

(d) Street No.

Registration District No.

Primary Registration District No.

Registered No.

(e) Length of residence in city or town where death occurred 50 yrs. mos. 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.

(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

Ray Allen

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

Feb 2 1868

7. AGE

YEARS

72

MONTHS

4

DAYS

19

If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

Hanswiler

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Kentucky

FATHER

13. NAME

William A. Harding

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Kentucky

MOTHER

15. MAIDEN NAME

Julia Crawford

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Ohio

X INFORMANT (ADDRESS)

Theo Allen McElley  
Humphreys, Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Humphreys

DATE

July 7

1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS)

D. R. McArthur  
East 1700

20. FILED

July 11

1940

Cuba Scott

Local Registrar

## MEDICAL CERTIFICATE OF DEATH

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

July 5 1940

22. I HEREBY CERTIFY, That I attended deceased from April 3 1940 to July 3 1940

I last saw him alive on July 3 1940 Death is said

to have occurred on the date stated above, at 7:30 P. M.

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

Carcinoma of Liver  
have high  
General Carcinoma

Date of onset

1935

Other contributory causes of importance:

Cancer of right breast  
Fracture of left thigh

1936

1940

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) J. R. McArthur

(Address) Brown, Mo.

J. M. D.

46  
RECEIVED

District Health Officer No. 10

District File Number 8-40-1596

Date Filed AUG 13 1940

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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

*P. K. Payne Jr.*

Licensed Embalmer No.

*3400*

P. O. Address

*Galt*

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

26497

Registration District No.

857

Primary Registration District No.

6119

Registrar's No.

1. PLACE OF BIRTH:

(a) County Sullivan  
(b) City or town Payson  
(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  
In this community. years, months or days)

3. (a) PRINT FULL NAME

Anna Laura 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

72

4

19

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

19. (a)

(Date received local registrar)

(b)

(Registrar's signature)

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 July day 5  
year 1940 hour 5 minute 5 M.

21. I hereby certify that I attended the deceased from 19 to 19

that I last saw him alive on the date and hour stated above.

Immediate cause of death Carcinoma of

Generalized Carcinoma

Due to 50 over

Due to 50 over

Other conditions Cancer of breast

Fracture of left thigh

Major findings: Of operations

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?

(Specify type of place)

While at work? (c) Means of injury

23. Signature G. R. McArthur (M. D. or other)

Address Crowning Date signed no

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

SUPPLEMENTARY

# Primary site of malignancy not definitely known.

Fracture due to malignancy #