

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

SEP 23 1940
Registration District No. 449

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28894

Primary Registration District No. 4267

Registrar's No.

1. PLACE OF DEATH

(a) County Laclede
(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wallace Memorial Hospital
(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

Cheo Allen 450

3. (b) If veteran,

name war _____

3. (c) Social Security

No. _____

4. Sex

M

5. Color or
race W

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if

alive _____ years

7. Birth date of deceased

July 18 1940
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

15 hr. _____ min.

9. Birthplace

Laclede Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name

Jahnnie Allen

13. Birthplace

Camden Co Mo
(City, town, or county) (State or foreign country)

14. Maiden name

Iressie Duggins

15. Birthplace

Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature

Jahnnie Allen

(b) Address

Lebanon Mo 64043

17. (a)

Burial

(b) Date thereof

8/4/40
(Month) (Day) (Year)

(c) Place: burial or cremation

Ira Cemetery

18. (a) Signature of funeral director

none

(b) Address

9-6-40

19. (a)

(Date received local registrar)

(b)

Jamie Tomb
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Laclede
(c) City or town Lebanon
(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 Aug day 4
year 1940 hour 4 minute 2 a. m.

21. I hereby certify that I attended the deceased from July 31
19 40 to Aug 3 19 40
that I last saw him alive on Aug 2 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death

Pneumonia

Duration

3 days

Due to _____

Due to _____

Other conditions

(Include pregnancy within 9 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

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?
40 (Specify type of place) _____ (e) Means of injury _____

23. Signature W. W. Wailaya (M. D. or other)
Address Lebanon Mo Date signed 8/8/40

109

RECEIVED

District Health Officer No. 7,

District File Number 9-40-1347

Date Filed 9-16-40

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 _____

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **28894**

Registration District No. **489**

Primary Registration District No. **4267**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Laclede**
(b) City or town **Lebanon**
(c) Name of hospital or institution:
(If outside city or town limits, write "RURAL" and name of township)

(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

Chas Allen

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

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year _____

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

8. AGE: Years _____ Months _____ Days **17** If less than one day _____ hr _____ 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) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month **Aug** day **4** year **1970** 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 **Pneumonia** Duration _____

Due to **Broncho pneumonia** 2 days

Due to **leukemia**

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____ 1072

Of operations _____

Of autopsy _____

PHYSICIAN

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 **W. J. Warloga** (M. D. or other) _____

Address **Lebanon Mo** Date signed _____

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

SUPPLEMENTAL

