S No. 2

I X23159

38

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. 32002

FILED OCT 1 1940

Registration District No. 513 Primary Registration District No. 5432 Registrar's No.

1. PLACE OF DEATH:
(a) County: Gentry
(b) City or town: Miller Township RR
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Kansas City Mo RR
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 (Specify whether years, months or days)
In this community 2

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Gentry
(c) City or town: Darlington Mo RR
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Victoria Allenbrand

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: widow

6. (b) Name of husband or wife: Isaac Allenbrand

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

7. Birth date of deceased: Apr (Month) 4 (Day) 1854 (Year)

8. AGE: Years 86 Months 5 Days 11 If less than one day ____ hr. ____ min.

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

10. Usual occupation: Housework

11. Industry or business: —

FATHER
12. Name: Henry Allen
13. Birthplace: Westfield England (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Matilda Willington
15. Birthplace: England (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs Percy Barker
(b) Address: Darlington Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-40 (Month) (Day) (Year)
(c) Place: burial or cremation Fairview

18. (a) Signature of funeral director: A. H. Taggart
(b) Address: King City Mo

19. (a) ____ (Date received local registrar) (b) Nora Mothershead (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 ~~20~~ day 20 year 1940 hour 9 — minute a — M.

21. I hereby certify that I attended the deceased from June 12th 1940, 1940, to Sept 20th 1940 that I last saw her alive on Sept 19th 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of Rectum	Unknown
Due to:	
Due to:	
Other conditions: Chronic nephritis (Include pregnancy within 3 months of death)	Unknown
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? Home (Specify type of place)
While at work? (e) Means of injury

23. Signature: W S Campbell (M. D. or other)
Address: Albany Mo Date signed SEP 23 1940

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11
District File Number
Date Filed

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 R. G. Teggart

Licensed Embalmer No. 2563

P. O. Address King City 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, fact should be so stated above.

V.-S. No. 2B
10M—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. 32002

Registration District No. 363 Primary Registration District No. 2432 Registrar's No.

1. PLACE OF DEATH:
(a) County Gentry
(b) City or town Miller
(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 Victoria Allenbrand
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 wd
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
86	8	11	hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER
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) Nov. 19 1940 (Date received local registrar) (b) Nora Motherstead (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 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.

Immediate cause of death — Duration
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.

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 W. S. Campbell (M. D. or other)
Address Albany Mo Date signed

SUPPLEMENTARY