

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2101
Registrar's No. 3

Registration District No. 124

Primary Registration District No. 4070

1. PLACE OF DEATH:

- (a) County CAPE GIRARDEAU
(b) City or town JACKSON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 35 years (years, months or days)

3. (a) PRINT FULL NAME MOLLIE ESTER ALLEN

3. (b) If veteran, name war _____ 3. (c) Social Security No. 495-14-9741

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE

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

7. Birth date of deceased DECEMBER 3 1900
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
40 1 25 hr. min.

9. Birthplace CAPE GIRARDEAU COUNTY MO
(City, town, or county) (State or foreign country)

10. Usual occupation SHOE FACTORY WORKER

11. Industry or business _____

MOTHER FATHER { 12. Name W. H. ALLEN
13. Birthplace CAPE GIRARDEAU COUNTY MO
(City, town, or county) (State or foreign country)
14. Maiden name SARAH WATTE STEARNS
15. Birthplace MILLENVILLE MO
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Effie M. Barrett
(b) Address JACKSON MO

17. (a) BURIAL (b) Date thereof 1 30 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation RUSSELL HEIGHTS

18. (a) Signature of funeral director WILSON-STATLEY SEABY
(b) Address JACKSON MO

19. (a) 1-30-41 (b) H. G. Seibert
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State MISSOURI (b) County CAPE GIRARDEAU
(c) City or town JACKSON
(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.? 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 28
year 1941 hour 2 minute 30 P. M.

21. I hereby certify that I attended the deceased from Jan 28-11 AM, 1941, to Jan 28-2:30 PM, 1941
that I last saw her alive on Jan 28, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 5 Pms

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? 1-30

(Specify type of place) (e) Means of injury _____
while at work?

23. Signature JOSEPH R. Deabachy (M. D. or other) 0
Address JACKSON MO Date signed 1-28

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.....

Glenn Wilson

Licensed Embalmer No. *2828*

P. O. Address *Jackson 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.