

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

6167
State File No. Three
Registrar's No. Three

FILED MAR 11 1941
Registration District No. 992

Primary Registration District No. 5047

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

1. PLACE OF DEATH:
(a) County Barry
(b) City or town Rural (Ozark Township)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Star Route Aurora Mo.
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Barry 5
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. Star Route Aurora Mo. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Ida C Allmon
(b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 3
year 1941 hour 1 minute 20 A.M.

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Wm N Allmon 6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jen, 14 1875
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 12, 1940 to Mar 1, 1941
that I last saw her alive on Dec 12, 1940
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>1</u>	<u>17</u>	hr. min.

Immediate cause of death Chronic myocarditis
Due to.....
Due to.....

Duration
about 3 years

9. Birthplace ? Kentucky
(City, town, or county) (State or foreign country)
10. Usual occupation Housewife

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.

11. Industry or business.....
12. Name John Hunt
13. Birthplace ? Kentucky
(City, town, or county) (State or foreign country)
14. Maiden name Martha Jane Nichols
15. Birthplace ? Kentucky
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. P. E. Ross
(b) Address Aurora Mo.
17. (a) Burial (b) Date thereof 3/4/41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Leann Cemetery
18. (a) Signature of funeral director J. L. King
(b) Address Aurora Mo.
19. (a) (Date received local registrar) (b) (Registrar's signature)

23. Signature W. H. Smith (M. D. or 0)
Address 12th Pleasant Aurora Date signed 3/3/41

RECEIVED

District Health Officer No. 8

District File Number 341-396

Date Filed MAR 7 1941

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 Herman Burridge
Licensed Embalmer No. 3072
P. O. Address Aurora 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6167

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 992

Primary Registration District No. 5047

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Barry

(b) City or town Ozark T.P.
(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 _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Ida C Allmon

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 wid

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 66 Months 1 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 _____

MOTHER FATHER { 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) May 5 - 41 (b) Dow Buchbinder (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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 3 year _____ 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 _____

Due to _____

Due to _____

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

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 J. H. Smith (M. D. or other) _____

Address Barry Mo Date signed _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

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

S-6167