DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 12 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 34805

Registration District No. _____ Primary Registration District No. 411 Registrar's No. _____

1. PLACE OF DEATH:
(a) County Caldwell
(b) City or town Kingston (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 _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Dunklin
(c) City or town Rural Buffalo (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 ALBERT-W. ALLEN

3. (b) If veteran, name war No
3. (c) Social Security No. None -

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Flora Allen
6. (c) Age of husband or wife if alive 28 years
7. Birth date of deceased Jan. (Month) 14 (Day) 1909 (Year)

8. AGE: Years 32 | Months 9 | Days 4 | If less than one day _____ hr. _____ min.

9. Birthplace Kennett (City, town, or county) Mo. U. (State or foreign country)
10. Usual occupation Farmer
11. Industry or business —

MOTHER FATHER
12. Name Tom Allen
13. Birthplace Dunklin Co. (City, town, or county) Mo. U. (State or foreign country)
14. Maiden name Wanda Varner
15. Birthplace Dunklin Co. (City, town, or county) Mo U (State or foreign country)

16. (a) Informant's own signature Jesse Lesson
(b) Address Caruthersville, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/41 (Month) (Day) (Year)
(c) Place: burial or cremation Caruthersville, Mo.
18. (a) Signature of funeral director E. T. Howard
(b) Address Leachville, Ark.
19. (a) _____ (Date received local registrar) (b) M. G. Moore (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 18
year 1941 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from July, 19 41, to August, 19 41; that I last saw h alive on August 15, 19 41; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Tuberculosis	years
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 Oct 18, 1941
(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. C. Thompson (M. D. or other)
Address Caruthersville Date signed 10-18-41

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should g
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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..... H. N. Howard

Licensed Embalmer No. 3959

P. O. Address Leachville, Ark.

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.

U. S. No. 2B
10M—8-21-41
I X29288

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. 34805

Registration District No. 283 Primary Registration District No. 4167 Registrar's No.

1. PLACE OF DEATH:
(a) County Franklin
(b) City or town Cardwell
(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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Albert W. 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 M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 14 (Day) 1909 (Year)

8. AGE: Years 32 Months 9 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Mo. (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) (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)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day
year 1941 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.

	Duration
Immediate cause of death Pulmonary Tuberculosis	
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.

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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 M. C. Clayworth (M. D. or other)
Address Cardwell Date signed 12-8-41