

No. 2
1-4-41
-17-39

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 36436

Registration District No. 9 J84

Primary Registration District No. 4549

Registrar's No. 49

1. PLACE OF DEATH:

(a) County Wright
(b) City or town Mont Grove Mo.
(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.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wright
(c) City or town Mont Grove Mo.
(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 Julia A Allen

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 w
6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive, years 15 1882
7. Birth date of deceased. Nov 15 1882
(Month) (Day) (Year)

8. AGE: Years 90 Months 8 Days 2 If less than one day
hr. min.

9. Birthplace OK Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name Unknown
13. Birthplace..... (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant W.A. Doyers
(b) Address Mont Grove

17. (a) Burial (b) Date thereof 7-20-41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Freeport

18. (a) Signature of funeral director Dep. Stapp
(b) Address Mont Grove Mo.

19. (a) 10-20-41 (b) Bernice Matzinger
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 17 year 1941 hour 8 minute 15 a. M.

21. I hereby certify that I attended the deceased from July 17 1941 to July 17 1941 that I last saw h. alive on July 17 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 3 days

Due to Infirmities of age

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations 83a
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 7/9/41 (Specify type of place) (e) Means of injury 0
Signature W.A. Doyers (M. D. or other) 0
Mountain View Date signed 7-24-41

031 (Licensed Embalmer's Statement on Reverse Side)

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

OCT 28 1941

DEC 27

DEC 27 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.....

Licensed Embalmer No. 3151

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, fact should be so stated above.