. No. 2
—9-4-41
5-17-39
I X29484

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

540

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 12 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

24245

State File No. .....

Registration District No. 290108 Primary Registration District No. 5408 4179 Registrar's No. 24

1. PLACE OF DEATH:

(a) County: Springfield

(b) City or town: Denneth, Texas

(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: Mo (b) County: Dunklin 35 2

(c) City or town: Dunath 0

(If outside city or town limits, write "RURAL")

(d) Street No. ..... (If rural, give location) 0

(e) Citizen of foreign country? ✓ (Yes or No)

If yes, name country ✓

3. (a) PRINT FULL NAME: Wanda Mae Allen

3. (b) If veteran, name war: ✓

3. (c) Social Security No. ✓

4. Sex: Female 2

5. Color or race: White

6. (a) Single, widowed, married, divorced: Single 0

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: 3 | Days: 2 | If less than one day ..... hr. ..... min.

9. Birthplace: Dunath (City, town, or county) Mo 0 (State or foreign country)

10. Usual occupation: Chef

11. Industry or business: ✓

MOTHER FATHER

12. Name: Raymond Allen

13. Birthplace: Ill (City, town, or county) (State or foreign country)

14. Maiden name: Ruth Mae Rice

15. Birthplace: Ky (City, town, or county) (State or foreign country)

16. (a) Informant: Raymond Allen

(b) Address: Dunath

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) H. O. Stereet (Registrar's signature)

1896 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 8 year 1942 hour 9 AM minute ..... M.

21. I hereby certify that I attended the deceased from Aug 8 1942, to Aug 8 1942, that I last saw him alive on Aug 8 1942, and that death occurred on the date and hour stated above.

Immediate cause of death: Acute dilatation of Heart — Duration

Due to: ✓

Due to: ✓

Other conditions (Include pregnancy within 3 months of death): ✓

Major findings: Of operations: ✓ 95C 4

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: ✓ 0

23. Signature: D. I. Dempsey (M. D. or other)

Address: Dunath MO Date signed 8-8-42

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.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

V. S. No. 2B
0M—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. 24248

Registration District No. 108 Primary Registration District No. 4179 Registrar's No. 24

1. PLACE OF DEATH:
(a) County: Dunklin
(b) City or town: Senath
(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: Wanda Mae 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: S.
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: May (Month) — (Day) 6 (Year) 1922
8. AGE: Years ..... Months 3 Days 28 If less than one day ..... hr. ..... min.
9. Birthplace: (City, town, or county) ..... (State or foreign country) Mo.
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: Aug. (Month) 9 (Day) 1942 (Year)
(c) Place: burial or cremation: Cude Cemetery
18. (a) Signature of funeral director: Had none
(b) Address .....
19. (a) Aug. 8 1942 (Date received local registrar) (b) H. O. Storey (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... Day ..... Year 1942 Hour ..... Minute ..... M.
21. I hereby certify that I attended the deceased from ..... 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	
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)
(b) 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 ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY