

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29180

State File No.

Registration District No.

Primary Registration District No. 3058

Registrar's No. 143

1. PLACE OF DEATH:

(a) County St. Charles
(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1721 No. 3rd St. 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)

3. (a) PRINT
FULL NAMEMrs. Betsy Iona Allen

3. (b) If veteran,

name war None

3. (c) Social Security

No. None4. Sex Female

5. Color or

race White

6. (a) Single, widowed, married,

Divorced Widowed

6. (b) Name of husband or wife.

W. W. Allen

6. (c) Age of husband or wife if

alive years

7. Birth date of deceased

December 8, 1863

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

7983

hr.

min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

Retired

11. Industry or business

12. Name John B. HutchinsonUnknownNew York

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

Unknown

15. Birthplace

UnknownUnknown

16. (a) Informant

George Allen

(b) Address

1721 No. 3rd St.17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof Aug. 14, 1943

(Month) (Day) (Year)

(c) Place: burial or cremation

Oak Grove Cemetery

18. (a) Signature of funeral director

Hackman, Ben

(b) Address

St. Charles, Mo.19. (a) 8/13/43

(Date received local registrar)

(b)

Ernest E. Paul

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles
(c) City or town St. Charles
(If outside city or town limits, write "RURAL")
(d) Street No. 1721 N. Third Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 11
year 1943 hour 2 minute - P.M.

21. I hereby certify that I attended the deceased from May II
1943, to 8- II 1943;
that I last saw her alive on Aug. II 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia

Duration

Due to Cerebral arteriosclerosisDue to Generalized arteriosclerosisOther conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

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 Outtamer (M. D. or other) MD
Address St. Charles, Mo. Date signed 8-13-43

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 the above constitutes grounds for revocation of license.)

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept.
Registrar's No. _____

Registration District No. 310

Primary Registration District No. 3058

1. PLACE OF DEATH:

(a) County St. Charles
(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1721 No. 3rd St.
(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

3. (a) PRINT FULL NAME Mrs. Betty Dona 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 _____

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

7. Birth date of deceased Dec. 8 (Month) (Day) (Year)

8. AGE: Years 79 Months 5 Days 1 If less than one day _____ min.

9. Birthplace Windsor, Iowa (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

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 Our Young Cemetery

18. (a) Signature of funeral director Heckman Paul

(b) Address St. Charles, Mo.

19. (a) 8-13-1943 (b) Ernest E. Paul (Date received local registrar) (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. Day 11 Year 1943 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____ Duration _____

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) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

PHYSICIAN

Underline the cause to which death should be charged statistically.

29180