

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34863

FILED OCT 29 1943

Registration District No. 140

Primary Registration District No. 4229

State File No. _____

Registrar's No. 69

1. PLACE OF DEATH:

(a) County **HOWARD**
(b) City or town **NEW FRANKLIN**
(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 **ONE YEAR**
years, months or days

3. (a) PRINT FULL NAME **MRS EINO RE ALLEE**

3. (b) If veteran, name war **NONE** 3. (c) Social Security No. **NONE**

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced, **WIDOWED**
6. (b) Name of husband or wife **DR. E.M. ALLEE** 6. (c) Age of husband or wife if alive **DECEASED**
7. Birth date of deceased **JULY 10 1870**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
73 3 1 hr. min.

9. Birthplace **MONITEAU COUNTY MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business **HOME**

12. Name **CAPT. H.A. YARNELL**
13. Birthplace **KENTUCKY**
(City, town, or county) (State or foreign country)
14. Maiden name **VIRGINIA DEFOE**
15. Birthplace **MISSOURI**
(City, town, or county) (State or foreign country)

16. (a) Informant **MRS. C.L. PAINTER**
(b) Address **NEW FRANKLIN, MISSOURI**
17. (a) **BURIAL** (b) Date thereof **OCT 12-1943**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial of cremation **BOONVILLE, MO.**

18. (a) Signature of funeral director **STEGNER & KOENIG**
(b) Address **BOONVILLE, MO.**

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **HOWARD**
(c) City or town **NEW FRANKLIN**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **OCTOBER** day **11th**
year **1943** hour **12:20** minute **A.M.**
21. I hereby certify that I attended the deceased from **July 1942** to **Oct 10 1943**
that I last saw her alive on **Oct 10 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac decompensation 2 wks**

Due to **Carcinomatous 2-3 yrs**

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration

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? _____ (Specify type of place) (e) Means of injury _____

23. Signature **M. P. Reech** (M.D. or other) **M.D.**
Address **Jayette, Mo** Date signed **10/11/43**

(Licensed Embalmer's Statement on Reverse Side)

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

1321

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 10-27-43

OCT 29

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 James W. Stegner

Licensed Embalmer No. 3780

P. O. Address Boonville, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. nov
Registration District No. 140 Primary Registration District No. 4229 Registrar's No. 69

1. PLACE OF DEATH:

(a) County Howard
(b) City or town New Franklin
(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)

3. (a) PRINT FULL NAME

Elmore Allee

3. (b) If veteran,

name war

3. (c) Social Security

No.

4. Sex

7

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

7. Birth date of deceased

July 10 1888
(Month) (Day) (Year)

8. AGE:

Years 73

Months 3

Days

Unless than one day

min.

9. Birthplace

(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

18. (a) Signature of funeral director

(b) Address

19. (a)

(Date received local registrar)

(b)

(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 Oct day 1
year 1943 hour 10 minute 30 M.

21. I hereby certify that I attended the deceased from 1943 to 1943; that I last saw him alive on Oct 1, 1943 and that death occurred on the date and hour stated above. Immediate cause of death Cardiac decompensation Duration 2 weeks

Due to Carcinomatosis 2-3 yrs.

Due to Carcinoma - ovary 6 yrs

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)
(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 M. P. Seel (M. D. or other)

Address Nov 3, 1943 Date signed Fayette, Mo.

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

SUPPLEMENTARY

34863