

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 17 1943
Registration District No. 356

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 43963
Registrar's No. _____

Primary Registration District No. 4494

1. PLACE OF DEATH

- (a) County Shannon
(b) City or town Wynona
(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution _____ (Specify whether)
In this community all life years, months or days

3. (a) PRINT FULL NAME

Jessie Allen

3. (b) If veteran,

name war _____

3. (c) Social Security

No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married

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

7. Birth date of deceased Mar 7 1861
(Month) (Day) (Year)

8. AGE: Years 82 Months 8 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business

- MOTHER FATHER { 12. Name Tom Allen
13. Birthplace Tenn.
(City, town, or county) (State or foreign country)
14. Maiden name Sara Paxton
15. Birthplace Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Lucinda Allen
(b) Address Wynona

17. (a) Burial (b) Date thereof Dec 4 43
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation Low Wasse

18. (a) Signature of funeral director Seaton Dewitt

- (b) Address Van Buren Mo

19. (a) 12-4-43 (b) Frank Hyde MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Mo (b) County Shannon
(c) City or town Wynona
(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.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 4 year 1943 hour 7 minute 10 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy 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) (e) Means of injury _____

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

Address Wynona Mo Date signed 12-4-43

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

RECEIVED

District Health Officer No. 5,

District File Number 1243717

Date Filed 12-15-43

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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed

Leaton Peritt

Licensed Embalmer No.

2287

P. O. Address

Van Buren 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, above space should be left blank.