S. No. 2
M—2-43
5-17-39
1 X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 9 1944

Registration District No. 52

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3009

State File No. 2360

Registrar's No.

1. PLACE OF DEATH:
(a) County CAPE-GIRARDEAU
(b) City or town Jackson 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
In this community 15 Months (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cape Girardeau 16
(c) City or town Jackson 2
(If outside city or town limits, write "RURAL") 1
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country /

3. (a) PRINT FULL NAME ROBERT-H. ALLEN

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Rachel Allen

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased Nov (Month) 11 (Day) 1868 (Year)

8. AGE: Years 75 | Months 1 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Bollinger (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 8
year 1944 hour 8 am minute 10 A.M.

21. I hereby certify that I attended the deceased from Jan, 1943 to Jan 7, 1944
that I last saw h~~is~~. alive on Jan 6, 1944
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	week
Due to arteriosclerosis	10 yr
Due to	
Other conditions Bronchitis (Include pregnancy within 3 months of death)	3 yr

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

MOTHER / FATHER
12. Name James Allen
13. Birthplace unknow (City, town, or county) 9 (State or foreign country)
14. Maiden name Jane McElhenney
15. Birthplace Bollinger (City, town, or county) Missouri (State or foreign country)

16. (a) Informant O. B. Allen
(b) Address Fisk Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-10-1944 (Month) (Day) (Year)
(c) Place: burial or cremation New Bethel Cem.

18. (a) Signature of funeral director Taylor Funeral Home
(b) Address Sikeston, Mo.

19. (a) Jan 11 44 (Date received local registrar) J. L. C. Kushner (Registrar's signature)

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

23. Signature T. E. Ruff (M. D. or other) MD
Address Jackson Mo. Date signed 1-10-44

1116

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 244-3374

Date Filed 2-8-44

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 with the above constitutes grounds for revocation of license.)

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