S. No. 2
—8-43
5-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 21 1944

Registration District No. 336

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42241

Primary Registration District No. 4494

Registrar's No.

1. PLACE OF DEATH:
(a) County Shannon
(b) City or town Winona (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: own home (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether In this community 2 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Shannon
(c) City or town Winona (If outside city or town limits, write "RURAL") 101
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Lucindy Allen
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F 1
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife Jesse Allen
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug (Month) 15 (Day) 1864 (Year)

8. AGE: Years 80 | Months 3 | Days 3 | If less than one day hr. min.

9. Birthplace Powell Co. Mo (City, town, or county) (State or foreign country)
10. Usual occupation House Wife
11. Industry or business

MOTHER FATHER
12. Name William Pomeroy
13. Birthplace Kentucky (City, town, or county) (State or foreign country)
14. Maiden name Nancy Mc Wharter
15. Birthplace U.S.A. (City, town, or county) (State or foreign country)

16. (a) Informant Elena Vanwinkle
(b) Address Mountenview Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-44 (Month) (Day) (Year)
(c) Place: burial or cremation Lowassie
18. (a) Signature of funeral director Beaton Pewitt
(b) Address Van Buren Mo
19. (a) 11-30-44 (Date received local registrar) (b) Frank Hyde MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 18
year 1944 hour 7 minute 45 M.

21. I hereby certify that I attended the deceased from Sept 1-1944, 19..., to Nov 18, 1944, that I last saw h. ex alive on Nov 18, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Arteriosclerosis	
Due to Myocarditis	
Due to	
Other conditions (Include pregnancy within 3 months of death) 93 yr	

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature W. L. Palmer (M. D. or other)
Address Winona Mo Date signed 11-18-44

744

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No 5,
District File Number 12-44-622
Date Filed 12-20-44

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 Seaton Penrith

Licensed Embalmer No. 2287

P. O. Address Van Buren Me

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.

S. No. 2B
)M—5-43
I X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

JAN

State File No.....

Registration District No. 336 Primary Registration District No. 4494 Registrar's No.....

1. PLACE OF DEATH:
(a) County Shannon
(b) City or town Winona
(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)

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 Lucinda 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 Widow
6. (b) Name of husband or wife Jesse
6. (c) Age of husband or wife if alive..... years
7. Birth date of deceased Aug (Month) 15 (Day) 1864 (Year)
8. AGE: Years 80 | Months 2 | Days | If less than one day ..... hrs. ..... min.
9. Birthplace ..... (City, town, or county) Mo (State or foreign country)
10. Usual occupation.....
11. Industry or business.....
FATHER 12. Name.....
13. Birthplace..... (City, town, or county) (State or foreign country)
MOTHER 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) Frank Hyde MD (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January 8
year 1944 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..... 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)
(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..... (M. D. or other).....
Address..... Date signed.....

S-42241 1944