

No. 2
8-43
17-39
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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

State File No. **30116**

FILED SEP 15 1947

Registration District No. **255** Primary Registration District No. **6205** Registrar's No. _____

1. PLACE OF DEATH:

(a) County **TEXAS**

(b) City or town **RURAL PIERCE TWP**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **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 **27 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Texas**

(c) City or town **Rural - Pierce Twp**
(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 _____

3. (a) PRINT FULL NAME **NANCY CLORINDA 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 **WIDOWED**

6. (b) Name of husband or wife **GEORGE ALLEN** 6. (c) Age of husband or wife if alive **DECEASED** years

7. Birth date of deceased **MAR - 9 - 1856**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **19** year **1947** hour **1 A.M.** minute _____ 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.

8. AGE:

Years	Months	Days	If less than one day
91	5	10	hr. _____ min. _____

Immediate cause of death **General arteriosclerosis**

Due to _____

Due to _____

9. Birthplace **INDIANA**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations **A7**

Of autopsy _____

11. Industry or business _____

12. Name **John Broadway**

13. Birthplace **Dont know**
(City, town, or county) (State or foreign country)

14. Maiden name **Elizabeth Logure**

15. Birthplace **Dont know**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs C. L. Vandeventer**

(b) Address **Stee Rt, Willow Springs, Mo.**

17. (a) **Burial** (b) Date thereof **8/19/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Clear Springs Cemetery**

18. (a) Signature of funeral director **JCB urns**

(b) Address **Willow Springs, Mo.**

19. (a) **9-19-47** (b) **MAS E. Murphy**
(Date received local registrar) (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? _____

While at work _____ (Specify type of place)

(e) Means of injury **D**

23. Signature **J. P. Callahan** (M. D. or other) _____

Address **Willow Springs, Mo.** Date signed **8/19/47**

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 5

District File Number 947488

Date Filed 9-12-47

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.

not embalmed

Signed.....

J. Burns
Licensed Embalmer No. 3379

P. O. Address Willow Spgs, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 355

Primary Registration District No. 6201

Registrar's No. _____

1. PLACE OF DEATH:
(a) County Texas
(b) City or town Rural
(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 Nancy C. Allen
(b) If veteran, name war _____
(c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day _____
year 1947 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.
Immediate cause of death _____

4. Sex F 5. Color or race W
6. (a) Single, widowed, married, divorced X
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: March (Month) 7 (Day) _____ (Year)
8. AGE: Years 91 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
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) Sept 19 - 47 (Date received local registrar) Mrs C E Murphy (Registrar's signature)

Due to _____
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. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

S-3011b