No. 2
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17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 30 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30592

Registration District No. 53 | Primary Registration District No. 3010 | Registrar's No. 289

1. PLACE OF DEATH

(a) County: Cape Girardeau
(b) City or town: Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Francis Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution, 8 days | In this community, Entire Life
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Cape Gir 16
(c) City or town: Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. 2 miles South Grand Hill 0
(If rural, give location)
(e) Citizen of foreign country? ✓ (Yes or No) 1
If yes, name country: ✓

3. (a) PRINT FULL NAME: GEORGE C. 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: Widowed 2

6. (b) Name of husband or wife: Elizabeth Bessy Allen | 6. (c) Age of husband or wife if alive: ✓ years

7. Birth date of deceased: July (Month) 27 (Day) 1855 (Year)

8. AGE:

Years	Months	Days	If less than one day
92	1	8	hr. min.

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

10. Usual occupation: Farming

11. Industry or business:

MOTHER FATHER

12. Name: William Allen
13. Birthplace: Ill. (City, town, or county) (State or foreign country)
14. Maiden name: Louisa Matthews
15. Birthplace: Mo. (City, town, or county) (State or foreign country)

16. (a) Informant: Chester Allen
(b) Address: Burfordville Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 7-1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Allen Cemetery

18. (a) Signature of funeral director: D Miller
(b) Address: Jackson

19. (a) 9-23-47 (Date received local registrar) (b) C. C. Summers (Registrar's signature) 111

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 5 year 1947 hour 3 minute 55 P.M.

21. I hereby certify that I attended the deceased from 8-28-21 1947, to 9-5- 1947, that I last saw her alive on 9-3- 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Lobar Pneumonia	3 days
Due to: Fractured hip	2 weeks
Due to:	
Other conditions: (Include pregnancy within 3 months of death)	

PHYSICIAN

Major findings:
Of operations: ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
Of autopsy: No

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: 16
(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: 0

23. Signature: T. E. Ruff (M. D. or other) M D
Address: Jackson Mo. Date signed 9/23/47

(Licensed Embalmer's Statement on Reverse Side)

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

Health Officer No. 4

District File Number 9-7-1243

Date Filed 9-29-47

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.

Signed Gene C Carroll

Licensed Embalmer No. 4327

P. O. Address Jackson, 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.

No. 2B
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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. Oct

Registration District No. 53 Primary Registration District No. 3010 Registrar's No. 299

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape Girardeau (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 years, months or days)

In this community

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** George C 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 Mad

6. (b) Name of husband or wife

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

7. Birth date of deceased July 27 (Month) (Day) 1865 (Year)

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

9. Birthplace Mo (City, town, or county) (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) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Oct Day 5 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.

	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.

SUPPLEMENTARY

146A 146

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence (August) 29 1947

(c) Where did injury occur? At Home - Drawl Hill Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? At home on farm (Specify type of place)

While at work? Yes (e) Means of injury Fall on tractor left hip fractured

23. Signature G. E. Ruff (M.D. or other) M.D

Address Jackson Mo Date signed 10-7-47

S-30592