

Registration District No. 243Primary Registration District No. 4313

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Newton
 (b) City or town Fairview
 (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)

3. (a) PRINT FULL NAME LURIA GERTRUDE ALLMAN

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, married
 6. (b) Name of husband or wife R. E. Allman 6. (c) Age of husband or wife if alive 75 years
 7. Birth date of deceased Feb 1 1875
 (Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | <u>72</u> | <u>6</u> | <u>14</u> | _____ hr. _____ min. |

9. Birthplace McDonnall County, Mo.
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business _____

12. Name William Bullard 913. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)14. Maiden name Sidney Ellen Rawlands 915. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)16. (a) Informant Letha Price 1(b) Address Stark City, Mo.17. (a) Burial (b) Date thereof 8-20-1947
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Dice Cemetery18. (a) Signature of funeral director Culver Funeral Home(b) Address Cassville Missouri19. (a) 8-24-48 (b) Alpha Dyer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton 73
 (c) City or town Fairview 0
 (If outside city or town limits, write "RURAL") 0
 (d) Street No. _____ (If rural, give location) 0
 (e) Citizen of foreign country? N. (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 15
year 1947 hour _____ minute _____ M.21. I hereby certify that I attended the deceased from Aug - 1 - 1947 to Aug 15 - 1947that I last saw him alive on Aug 10 - 1947 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Endocarditis Chronic 10 yr.
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 023. Signature O. S. McCall (M. D. or other) _____Address Wheaton Mo Date signed 8-23-47

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.....

Ruby Elkins

Registered Apprentice No.

496

working under my personal supervision.

Signed.....

A. E. Culver

Licensed Embalmer No.

3584

P. O. Address.....

Cassville

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.

2B
3-45
X43880

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44705
State File No. March

Registration District No. 243

Primary Registration District No. 4363

Registrar's No. _____

1. PLACE OF DEATH: Newton

(a) County.....

(b) City or town..... Farmville

(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..... (Specify whether)

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 Juria G. Allman

3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1944 Year 1944 hour 11 minute 15 M.

21. I hereby certify that I attended the deceased from 1944 to 1944; that I last saw him alive on 3-3-1944 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 m

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased Feb 1 (Month) 1 (Day) 1944 (Year)

Due to.....

Due to.....

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

8. AGE: Years 72 Months 6 Days 1 If less than one day hr. min.

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

Major findings:
Of operations.....

Of autopsy.....

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)

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) (c) Means of injury.....

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

13. (a) Signature of funeral director.....

(b) Address.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

19. (a) 3-3-1948 (b) Alpha Dye

(Date received local registrar) (Registrar's signature)

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

SUPPLEMENTARY

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

S-44705