N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

AUG 10 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

25140
Do not use this space.

1. PLACE OF DEATH
(a) County Butler Registration District No. 89
(b) Township ~~Poplar Bluff~~ Primary Registration District No. 3007 Registered No. 180
or
(c) City Poplar Bluff Mo (d) Street No. Brandon Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 450 Gilford T Allen
(a) Residence, No. Patterson Mo. R1 St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR WIFE OF)~~ Virginia
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-1-1917
7. AGE YEARS 22 MONTHS 1 DAYS 13 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wayne Co.

FATHER
13. NAME Raney Allen
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wayne Co

MOTHER
15. MAIDEN NAME Sally Yancey
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wayne Co

17. INFORMANT (ADDRESS) Father Raney Allen Wayne Co.
18. BURIAL, CREMATION, OR REMOVAL PLACE Bounds Creek-Wayne Co DATE 7-16-39, 19
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Cray Fun Home Greenville Mo.
20. FILED 7/16, 1939 O. Lutsinger Local Registrar.

MEDICAL CERTIFICATE OF DEATH 5 A.M.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 15, 1939
22. I HEREBY CERTIFY, That I attended deceased from July 15 - 1939, to July 15 - 1939
I last saw him alive on July 15, 1939. Death is said to have occurred on the date stated above, at 5 a. m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary oedema	July 15-1939
Myocardial failure	
Other contributory causes of importance:	
Malaria	July 7-1939

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) F. A. Kneibert M. D.
89 (Address) Poplar Bluff, Mo

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.