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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
N 12 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42902

Registration District No. 39 | Primary Registration District No. 5131 | Registrar's No. 300

1. PLACE OF DEATH:
(a) County Butler
(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 years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Butler
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. ____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME KATE ALLEN 452
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 ____
6. (b) Name of husband or wife John T. Allen
6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased NOV (Month) 20 (Day) 1874 (Year)

8. AGE: Years 65 | Months 0 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Wayne Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation Housewife
11. Industry or business ____
12. Name Richard Fudge (FATHER)
13. Birthplace ____ (City, town, or county) England (State or foreign country)
14. Maiden name Unknown (MOTHER)
15. Birthplace ____ (City, town, or county) England (State or foreign country)
16. (a) Informant's own signature Roy J. Allen
(b) Address Williamsville Mo RFD 1
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 10 1939 (Month) (Day) (Year)
(c) Place: burial or cremation Chapel Hill Cemetery
18. (a) Signature of funeral director N. T. Phillips
(b) Address Poplar Bluff Mo
19. (a) 12/10/1939 (Date received local registrar) (b) O. Christensen (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 9 year 1939 hour 9 minute 50 A.M.

21. I hereby certify that I attended the deceased from Feb 18 1937 to Dec 9 1939; that I last saw her alive on Dec 8 1939 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	3 yr
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 J. Scott Arnold (M. D. or other)
Address Poplar Bluff Mo Date signed 12/14/39

(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.

Signed. J. T. Phelps

Licensed Embalmer No. 3231

P. O. Address. Poplar Bluff Mo

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

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

42902
Do not use this space.

1. PLACE OF DEATH
(a) County Butler Registration District No. 89
(b) Township Paplar Bluff Primary Registration District No. 3131 Registered No. 300
(c) City ..... (d) Street No. ..... 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 Kate Allen
(a) Residence, No. ..... 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 F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)
7. AGE YEARS 65 MONTHS 0 DAYS 19 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. .....
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) .....

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) .....

17. INFORMANT (ADDRESS) .....
18. BURIAL, CREMATION, OR REMOVAL
PLACE ..... DATE ..... 19...
19. FUNERAL DIRECTOR (ADDRESS) .....
20. FILED 2/8 1940 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 9, 1939
22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ..... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset

Other contributory causes of importance:

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? .....
If so, specify .....
(Signed) J. Lee Harwell, M. D.
(Address) Paplar Bluff Mo

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.