

Registration District No. 273

Primary Registration District No. 6018A

Registrar's No. 121

1. PLACE OF DEATH:

(a) County St. Francois *St Fran*

(b) City or town Farmington

(c) Name of hospital or institution: State Hospital No. 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 27 yrs. 1 mo. 2 d
(Specify whether years, months or days)

In this community 3
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott

(c) City or town County Farm
(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.

8. (a) PRINT FULL NAME Frances Allen 450

3. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Dec. 22nd, 1888
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>51</u>	<u>6</u>	<u>18</u>	hr. _____ min. _____

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

10. Usual occupation Housekeeper

11. Industry or business _____

MOTHER FATHER { 12. Name Frank Allen 6

13. Birthplace Tennessee
(City, town, or county) (State or foreign country)

14. Maiden name Nancy Doudy

15. Birthplace Sikeston Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Records of State Hospt. #4

(b) Address Farmington, Mo.

17. (a) Burial (b) Date thereof 6-21-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place; burial or cremation Sikeston Mo.

18. (a) Signature of funeral director J. J. Robinson

(b) Address Sikeston Mo.

19. (a) June 17-40 (b) T. J. Robinson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 16
year 1940 hour 4 minute 20 p. M.

21. I hereby certify that I attended the deceased from 8-17, 1937, to 6-16, 1940;
that I last saw h. er alive on 6-16, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Pernicious Anemia 2 yrs
Fracture of left tibia and fibula

Duration _____

Due to _____

Due to _____

Other conditions Fracture of left tibia and fibula
(Include pregnancy within month 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? Y

23. Signature Paul J. Robinson 1
(Specify type of place) (c) Means of injury

Address Farmington, Mo. Date signed _____

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

144 B
99

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 *John A. Britton*
Licensed Embalmer No. 2941
P. O. Address *Titusville*

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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **22736**

Registration District No. **773**

Primary Registration District No. **6018A**

Registrar's No. **121**

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

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town St. Francois
(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 Frances 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 2

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 51 Months 6 Days 18 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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

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) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 16 year 1940 hour _____ 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.

Immediate cause of death Pneumonia Duration _____

Due to _____

Due to _____

Other conditions Fracture of left tibia + fibula

(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) accident

(b) Date of occurrence 6-2-40

(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? home

While at work? no (Specify type of place) _____ (e) Means of injury fall

23. Signatory Paul J. Schouder, M.D. (M. D. or other) _____

Address Farmington Day signed no

SUPPLEMENTAL

Underline the cause to which death should be charged statistically.

S-22736