No. 2
-17-40
X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38373

Registration District No. 125 Primary Registration District No. 3009 Registrar's No. 394

243

FILED DEC 7

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) 5 weeks

In this community 3

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis, Mo (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

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

3. (a) PRINT FULL NAME Jackie Wayne 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 Single

6. (b) Name of husband or wife

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

7. Birth date of deceased February (Month) 25 (Day) 1940 (Year)

8. AGE: Years 0 Months 8 Days 26 If less than one day hr. min.

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

10. Usual occupation Child

11. Industry or business

FATHER
12. Name Paul E. Allen
13. Birthplace Cape Girardeau (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Gulnie Doggett
15. Birthplace Cape Girardeau (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Paul E. Allen

(b) Address St Louis, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-1940 (Month) (Day) (Year)

(c) Place: burial or cremation Halbo Chapel Cemt

18. (a) Signature of funeral director L. L. Haman

(b) Address Cape Girardeau, Mo.

19. (a) 11-22-40 (Date received local registrar) (b) J. M. Thompson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 21st year 1940 hour 3 minute A.M.

21. I hereby certify that I attended the deceased from Nov. 19-40, 1940 to 11-20, 1940; that I last saw him alive on 11-20, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pneumonia Broncho	4 days
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)

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While at work? (e) Means of injury

23. Signature Frank W Hall (M. D. or other) M.D.

Address Cape Girardeau, Mo. Date signed 11-22-40.

(Licensed Embalmer's Statement on Reverse Side)

1072

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 Howard L. Haman

Licensed Embalmer No. 4122

P. O. Address Cape Girardeau

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

If this body is not embalmed, fact should be so stated above.

No. 2B
2-21-40
I X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38373

Registration District No. 125 Primary Registration District No. 3007 Registrar's No.

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

ROUEN

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Cape Gir

(b) City or town Cape Gir
(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)

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.

3. (a) PRINT FULL NAME Jackie Wayne 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 S

6. (b) Name of husband or wife

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

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

8. AGE: Years | Months 8 | Days 26 | If less than one day hr. min.

9. Birthplace (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 Nov day 21
year 1940 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 Pneumonia Bronchs.	8 days
Due to —	
Due to —	
Other conditions None (Include pregnancy within 3 months of death)	
Major findings: Of operations None	
Of autopsy None	

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 Frank W. Hall M.D. (M. D. or other)
Address Cape Girardeau Mo. Date signed 2-3-41