

No. 2
11-10-39
17-39
X2149

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

10414 ✓

FILED APR 2 1943

State File No. _____

Registration District No. 148

Primary Registration District No. 4238

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Buckner
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Buckner Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 das
(Specify whether years, months or days)

In this community 41 yrs
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Mo. (b) County Jackson

(c) City or town Buckner RR No. 1.
(If outside city or town limits, write "RURAL")

(d) Street No. RR No. 1.
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? XX years 0

3. (a) PRINT FULL NAME Mr. LEO ALLEN

3. (b) If veteran, name war X

3. (c) Social Security No. X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Febr. day 22
year 1943 hour 9 minute A M.

21. I hereby certify that I attended the deceased from 2-20
1943 to 2-22 1943

4. Sex Male 5. Color or race white

6. (a) Single, widowed, married, divorced single
WIDOWER

6. (b) Name of husband or wife deceased

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

7. Birth date of deceased Jan 1st 1872
(Month) (Day) (Year)

that I last saw him alive on Febr. 22nd. 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia

Duration Febr

8. AGE: Years 71 Months 1 Days 2
If less than one day hr. _____ min. _____

Due to myocardial degeneration

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

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

10. Usual occupation Farmer

11. Industry or business his own farm

12. Name Reuben Allen

13. Birthplace Ray County Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Mariah Offutt

15. Birthplace Ray County Mo.
(City, town, or county) (State or foreign country)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Thomas Allen

(b) Address Richmond Mo.

17. (a) Burial (b) Date thereof 2/23/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Buckner Cemetery

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

18. (a) Signature of funeral director T. M. Reppert

(b) Address Buckner Mo.

19. (a) 2/22/43 (b) T. M. Reppert
(Date referred local registrar) (Registrar's signature)

23. Signature L. W. Higgins (c) D. of signing 2/22/43

Address Buckner Mo. Date signed _____

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

008

1151

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 _____

working under my personal supervision.

Registered Apprentice No. _____

Signed P. M. Reppert

Licensed Embalmer No. 2321

P. O. Address Buckner Mo

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10814

Registration District No. 148

Primary Registration District No. 4238A

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Buckner
(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 Leo 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 71 Months 1 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry of business _____

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) _____ (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)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
that I saw him _____
and that death occurred on the date and hour stated above.
Immediate cause of death Supperstatia pneumoniae Duration _____

Due to myocardial degeneration

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature D. W. Higgins (M.D. or other) Do
Address Buckner, Mo. Date signed _____

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

SUPPLEMENTARY 22

