

Registration District No. _____ Primary Registration District No. **4194**

1. PLACE OF DEATH:
 (a) County **Gentry**
 (b) City or town **Albany**
 (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)

3. (a) PRINT FULL NAME **Lydia Luana Allen**
 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 **widowed**
 (b) Name of husband or wife **Stewart Whitley Allen** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Jan. 23 1865**
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	82	5	4	hr. _____ min. _____

9. Birthplace **Jamestown New York**
 (City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business _____

12. Name **James Monroe Worden**

13. Birthplace **New York**
 (City, town, or county) (State or foreign country)

14. Maiden name **Mary Jane Ross**

15. Birthplace **New York**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Clayton Allen**

(b) Address **Rockport, Mo.**

17. (a) **Burial** (b) Date thereof **6/29/47**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Grandview**

18. (a) Signature of funeral director **Walter Bush**
 (b) Address **Albany Mo.**

19. (a) **July 11-1947** (b) **Home D. Nelson**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Gentry**
 (c) City or town **Albany**
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **27**
 year **1947** hour **6** minute **35 P.M.**

21. I hereby certify that I attended the deceased from **June 22nd** 19**47** to **June 27th** 19**47**
 that I last saw h_er alive on **June 27th** 19**47**
 and that death occurred on the date and hour stated above.

Immediate cause of death **acute Cerebral Hemorrhage**
 Due to _____

Due to **Chronic Interstitial Nephritis**
 Other conditions (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) _____
 (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 **W. S. G. Griffith** (M. D. or other)
 Address **Albany Mo.** Date signed **7-29-47**

Duration

5 days

unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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 me
....., Registered Apprentice No.
working under my personal supervision.

Signed Robert Brooks
Licensed Embalmer No. 3329
P. O. Address Albany 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, fact should be so stated above.