APPLICATION FOR \$75.00 WIDOW BENEFIT

*When completed, email to adloveless@mckeancou	ntypa.org or fax to
814-887-3101. If sending by mail:	
Alvin D Loveless	
500 W. Main St.	
Smethport, PA 16749	
Full name of deceased widow:	
	(b) Place of Death:
(a) Date of Death: (c) Date of Burial:	(d) Place of Burial:
Legal Residence of the veteran at the time of his/l	
Street:	
City/State/Zip:	
County:	
, <u> </u>	
Full name of deceased veteran:	
(a) Place of Birth:	
Branch of Service Served:	Rank:
Discharge date:	
Type of Discharge:	Social Security #:
Please provide the following information about th	e veteran's death and hurial:
Death Date: Burial Date:	Place:
Burial Bate.	Name of Cemetary: Location of Cemetary:
All expenses of burial:	
Have been paid	
Have not been paid	
Thus, payment of this allowance shall be made to:	
Name:	Name of Firm:
Address:	Address:
Address.	Address.
Signature	Signature/Title
	Places shares to: 01406000 E10300
	Please charge to: 01406900-510200

Director of Veterans Affairs

APPLICATION FOR \$75.00 BURIAL EXPENSE

-	
314-887-3101. If sending by ma	d:
Alvin D Loveless	
500 W. Main St.	
Smethport, PA 16749	
Full name of deceased veter	ın:
(a) Place of Birth:	(b) Date of Birth:
Branch of Service Served:	<u> </u>
Discharge date:	Rank:
Type of Discharge:	Social Security #:
	ormation about the veteran's death and burial:
Death Date:	Place:
Burial Date:	Name of Cemetary:
	Location of Cemetary:
egal Residence of the veteran	at the time of his/her death:
Street:	
City/State/Zip:	
County:	
All expenses of burial:	
Have been paid	
	; J
Have not been page	id
Thus, payment of this allowanc	shall be made to:
Name:	Name of Firm:
Address:	Address:
Signature	Signature/Title
Director of Veterons Aff	Please charge to: 01406900-510200
Director of Veterans Aff	III 5

APPLICATION FOR \$60.00 MARKER EXPENSE

	emckeancountypa.org or fax to
814-887-3101. If sending by mail:	
Alvin D Loveless	
500 W. Main St.	
Smethport, PA 16749	
Full name of deceased veteran:	
(a) Place of Birth:	(b) Date of Birth:
Branch of Service Served:	
Discharge date:	
Type of Discharge:	Casial Casanita, H.
Please provide the following information Death Date: Burial Date:	Discourse
Legal Residence of the veteran at the tim	
Street:	
City/State/Zip:	
County:	
All expenses of burial:	
Have been paid	
Have not been paid	
Thus, payment of this allowance shall be	e made to:
Name:	Name of Firm:
Address:	Addross:
Address.	Address.
Signature	Signature/Title
Director of Veterans Affairs	Please charge to: 01406900-510901