

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Linn
Township Eleon
OR
Village Steffens
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 485
Primary Registration District No. 5648

File No. 38655

Registered No. _____

[If death occurred in hospital or institution give its NAME instead of street and number]

FULL NAME Ammonia Allen

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH May 11, 1858 (Month) (Day) (Year)
AGE 82 yrs. 7 mos. 6 ds. IF LESS than 1 day, ____ hrs. or ____ min.?
OCCUPATION (a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 109th
BIRTHPLACE (City or town, State or foreign country) Ky

PARENTS
NAME OF FATHER _____
BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky
MAIDEN NAME OF MOTHER Ammonia Stegg
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Yona Steele
(ADDRESS) Steffens
Filed 191 REGISTRAR OT Lee

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 12 1918
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 6, 1918, to Dec 12, 1918, that I last saw him alive on Dec 16, 1918, and that death occurred, on the date stated above, at 69 m. The CAUSE OF DEATH* was as follows:

Arteriosclerosis
+ (Duration) ____ yrs. ____ mos. ____ d.
Contributory Bronchitis (SECONDARY) (Duration) ____ yrs. ____ mos. ____ d.
(Signed) _____ M. D.
, 1918 (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ d.
Where was disease contracted If not at place of death?
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Steffens DATE OF BURIAL Dec 17, 1918
UNDERTAKER James Cadon ADDRESS Steffens

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more.

Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF

MISSC

PLACE OF DEATH

County _____

Township _____

or _____

Village _____

or _____

City _____

(NO. _____)

Registration District No. _____

Primary Registration District No. _____

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(If file the word)

DATE OF BIRTH

AGE

(Month) _____ (Day) _____ (Year) _____

IF LESS than
1 day, _____ hrs.
or _____ min.?
_____ yrs. _____ mos. _____ ds.

OCCUPATION

(a) Trade, profession, or
particular kind of work

(b) General nature of industry,
business, or establishment in
which employed (or employer)

BIRTHPLACE

(City or town,
State or foreign country)

NAME OF
FATHER

BIRTHPLACE
OF FATHER

(City or town, State or foreign country)

MAIDEN NAME
OF MOTHER

BIRTHPLACE
OF MOTHER

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(ADDRESS)

Filed

191 _____

REGISTRAR

MED

DATE OF DEATH

I HERE

that I last saw _____
and that death of _____
The CAUSE OF I

Contributory
(SECONDARY)

(Signed)

*State the Disease
(1) Means of Injury and

LENGTH OF RESIDENCE
RECENT RESIDENTS

At place
of death _____ yrs.

Where was disease
if not at place of

Former or
usual residence

PLACE OF BURIAL

UNDERTAKER