

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.

PLACE OF DEATH

County LeinoTownship Salmonor ShippensburgVillage Shippensburg

or

City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 485File No. 38656Primary Registration District No. 3648

Registered No. _____

FULL NAME Dwight T Allen

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

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male Ammon

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

DATE OF BIRTH

Sept 12, 190
(Month) (Day) (Year)

AGE

4 yrs. 4 mos. 12 ds.
If LESS than
1 day, ___ hrs.
or ___ min.?

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

Sequent

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

BIRTHPLACE

(City or town,
State or foreign country)

Musson

PARENTS

NAME OF FATHER

Robert Allen

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Mo

MAIDEN NAME OF MOTHER

Kate Truip

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. G. Allen

(ADDRESS)

Shippensburg

Filed

Dec 20, 1910Dr. P. F. Calk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

Dec 15, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from
Dec 12, 1910, to Dec 15, 1910,
that I last saw h alive on Dec 12, 1910,
and that death occurred, on the date stated above, at 69 m.
The CAUSE OF DEATH* was as follows:

Pneumonia
10711

(Duration) ___ yrs. ___ mos. 7 ds.

Contributory

(SECONDARY)

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) Paul F. Gile M. D.Dec 24, 1910 (Address) Shippensburg

*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, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted
if not at place of death?

Former or
usual residence

PLACE OF BURIAL OR REMOVAL

Shippensburg

DATE OF BURIAL

Dec 20, 1910

UNDERTAKER

J. Codner

ADDRESS

1st Bell

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

MISSOURI STATE BOARD
BUREAU OF VITAL STA
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____
Township _____
or
Village _____
or
City _____ (NO. _____)
Registration District No. _____ File No. _____
Primary Registration District No. _____ Registered No. _____

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

St. _____ Ward _____

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)		
AGE _____ yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min. ?		

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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH	_____ (Month) _____ (Day) _____ (Year)
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I HEREBY CERTIFY, that I attended deceased from _____, 191 _____, to _____, 191 _____, that I last saw h _____ alive on _____, 191 _____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)
_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds. M. D. _____ (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, or Recent Residents)
At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL DATE OF BURIAL _____ 191 _____

UNDERTAKER ADDRESS _____