

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 Linn
 Township Calmar
 or
 Village Shippensburg
 or
 City _____ (NO. _____ St.: _____ Ward)

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

Registration District No. 486 File No. 38657
 Primary Registration District No. 5648 Registered No. _____

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

FULL NAME American Allen

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE American SINGLE ☒ MARRIED ☐ WIDOWED ☐ OR DIVORCED ☐ (If write the word)

DATE OF BIRTH Nov 12 1894
 (Month) (Day) (Year)

AGE 76 yrs. 8 mos. 12 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) X

BIRTHPLACE
 (City or town, State or foreign country) Mo

PARENTS
 NAME OF FATHER E. Pallock
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Ky
 MAIDEN NAME OF MOTHER Dart Kinn
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. F. Gale
 (ADDRESS) Shippensburg

Filed 12-26 1910 D. F. Gale REGISTRAR

☒ MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 18 1910
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 10, 1910, to Dec 18, 1910, that I last saw him alive on Dec 16, 1910, and that death occurred, on the date stated above, at 10 Pm. The CAUSE OF DEATH* was as follows:

Pneumonia
109 H
100 (Duration) yrs. mos. ds.

Contributory Pharyngeal Branchitis
 (SECONDARY) (Duration) yrs. mos. ds.
 (Signed) D. F. Gale M. D.
Jan 26, 1911 (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 27 1910
 UNDERTAKER J. C. Cook ADDRESS La Belle

