

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

PLACE OF DEATH

County Levitt

Township Salem

or Village Steffenville, Mo.

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

Registration District No. 485-

File No. 6953

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 Margory Allen

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Female

White

Single

DATE OF BIRTH

Feb 26, 1910
(Month) (Day) (Year)

AGE

X yrs. 11 mos. 16 ds.

If LESS than
1 day, ___ hrs.
or ___ min.?

OCCUPATION

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

X

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

X

O

BIRTHPLACE

(City or town, State or foreign country)

Steffenville, Mo.

NAME OF FATHER

Frank Allen

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

Steffenville, Mo.

MAIDEN NAME OF MOTHER

Sallie Wayercraft

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

Steffenville, Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. G. Allen

(ADDRESS)

Steffenville, Mo.

Filed

Feb 20, 1911

Paul F. Cole, M.D.

REGISTRAR

DATE OF DEATH

Feb 10, 1911
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 20, 1911, to Feb 26, 1911, that I last saw her alive on Feb 25, 1911, and that death occurred, on the date stated above, at 2337 m.

The CAUSE OF DEATH* was as follows:

Pneumonia with cerebral complication

10 1/2 hr (Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY)

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

(Signed) Paul F. Cole M. D.
Feb 18, 1911 (Address) Steffenville, Mo.

*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

Steffenville, Mo.

DATE OF BURIAL

Feb 12, 1911

UNDERTAKER

E. C. Steffen

ADDRESS

[Signature]

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.

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

MISSOURI STATE

BUREAU OF

CERTIFICATION

PLACE OF DEATH

County _____
 Township _____
 or _____
 Village _____
 or _____
 City _____

Registration District No. _____

Primary Registration District No. _____

(NO. _____) St. _____

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) _____

REGISTRAR _____

MEDICAL CERTIFICATE

DATE OF DEATH _____

I HEREBY CERTIFY

_____ 191____
 that I last saw h_____ alive on _____
 and that death occurred, on th _____
 The CAUSE OF DEATH* was _____

Contributory

(SECONDARY)

(Signed) _____

(Duration) _____

(Duration) _____

(Address) _____

* State the Disease Causing Death, (1) Means of Injury; and (2) whether Ac

LENGTH OF RESIDENCE (For Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

UNDERTAKER