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.

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

PLACE OF DEATH

County: Dunklin

Township: Salem

or Village:

or City: (NO. St.; Ward)

Registration District No. 240 — File No. 34265

Primary Registration District No. 5408 — Registered No. 141

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

FULL NAME Katie Lea Allison

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): single

DATE OF BIRTH: (Month) (Day) 1 (Year)

AGE: 1 yrs. 10 mos. ds. — If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

BIRTHPLACE (City or town, State or foreign country): Near Senath Mo

PARENTS

NAME OF FATHER: Will Allison

BIRTHPLACE OF FATHER (City or town, State or foreign country): Salem twp Mo

MAIDEN NAME OF MOTHER: Florance Hinman

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Crawleys Ridge Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jim Allison

(ADDRESS) Senath Mo

Filed Oct 9th 1911. B L Ellis M-D. REGISTRAR

2

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Oct (Month) 8 (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Oct 1, 1911, to Oct 8, 1911, that I last saw her alive on Oct 8, 1911, and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

9 Malarial Fever

38

8

(Duration) yrs. mos. 12 ds.

Contributory (SECONDARY): Whooping cough

(Duration) yrs. 1 mos. 7 ds.

(Signed) [illegible] M. D.

Oct 9, 1911 (Address) Senath 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: Senath Cemetery

DATE OF BURIAL: Oct 9th 1911

UNDERTAKER: C. P. McDaniell

ADDRESS: Senath, Mo.

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

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. .... St.; ..... Ward)

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

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(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)

PARENTS

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

....., 191.....
(Month) (Day) (Year)

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:

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

Contributory .....
(SECONDARY)

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

(Signed) ..... M. D.

....., 191..... (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

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state