

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.

PLACE OF DEATH			MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH		
County	<i>Mississippi</i>		Registration District No.	<i>996</i>	
Township	<i>North</i>		Primary Registration District No.	<i>5766</i>	
or Village			Registered No.	<i>19986</i>	
or City	(NO. _____) _____		St.	Ward _____	
FULL NAME <i>Lorenda Lee Allen</i>			[If death occurred in a hospital or institution, give its NAME instead of street and number]		
PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH		
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If write the word)	DATE OF DEATH		
<i>Female</i>	<i>white</i>	<i>Single</i>	<i>June 7, 1914</i> (Month) (Day) (Year)		
DATE OF BIRTH	I HEREBY CERTIFY, that I attended deceased from <i>June 4, 1914</i> , to <i>June 7, 1914</i> , that I last saw <i>her</i> alive on <i>June 7, 1914</i> , and that death occurred, on the date stated above, at <i>10 P.M.</i>				
<i>Aug. 1, 1912</i> (Month) (Day) (Year)	The CAUSE OF DEATH* was as follows: <i>Whooping Cough</i>				
AGE	<i>117A 104</i> (Duration) _____ yrs. _____ mos. _____ ds.				
<i>1 yrs. 10 mos. 6 ds.</i>	Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.				
OCCUPATION (a) Trade, profession, or particular kind of work	<i>None</i>				
(b) General nature of industry, business, or establishment in which employed (or employer)	_____				
BIRTHPLACE (City or town, State or foreign country)	<i>Missouri</i>				
PARENTS	NAME OF FATHER	<i>William H. Allen</i>			
	BIRTHPLACE OF FATHER (City or town, State or foreign country)	<i>Carlisle, Mo.</i>			
	MAIDEN NAME OF MOTHER	<i>Pella Leithman</i>			
	BIRTHPLACE OF MOTHER (City or town, State or foreign country)	<i>Carroll, Mo.</i>			
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
(Informant)	<i>Maie Allen</i>				
(ADDRESS)	<i>Crossed Mo.</i>				
PLACED OF BURIAL OR REMOVAL	DATE OF BURIAL		LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)		
<i>Crossed Mo.</i>	_____ 1914		At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.		
UNDERTAKER	ADDRESS		Where was disease contracted If not at place of death?		
<i>C. W. Gray</i>	<i>Columbus, Mo.</i>		Former or usual residence _____		
REGISTRAR	FILED		PLACED OF BURIAL OR REMOVAL		
<i>D. B. Dick</i>	<i>6/7 1914</i>		<i>Crossed Mo.</i>		

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*, *Composer*, *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 precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sar-*

coma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *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 INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



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PLACE OF BIRTH

County Miss Co

Township Miss

Village _____

City _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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

Registration District No. 996

Primary Registration District No. 5766

File No. _____

Registered No. 3

(No. _____ St. _____ Ward _____)
FULL NAME Gonidy Lee Allen

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

PERSONAL AND STATISTICAL PARTICULARS

SEX M COLOR OR RACE W SINGLE MARRIED WIDOWED OR DIVORCED S
(If write the word)

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

AGE _____
IF LESS than 1 day, _____ hrs or _____ min
_____ 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) _____

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 9/7 1914 J. D. B. Dick REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____
(Month) 6/7 (Day) _____ (Year) 1914

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) _____ 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 6/8 1914

UNDERTAKER E. W. Avery ADDRESS Columbus Ky

Revised United States Standard Certificate of Death

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

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