

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

PLACE OF DEATH

County Jacks
Township Clay
or
Village
or
City

Registration District No. 428 File No. 3316111
Primary Registration District No. 359A Registered No. 24761
(NO. Masonic Homes St. Ward)

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

FULL NAME Osceola C. Allen

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE Col SINGLE MARRIED WIDOWED OR DIVORCED (If write the word) Single
DATE OF BIRTH July 15, 1868
(Month) (Day) (Year)
AGE 46 yrs. 7 mos. 27 ds. IF LESS than 1 day, ___ hrs. or ___ min.?
OCCUPATION (a) Trade, profession, or particular kind of work Cook & porter
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Waco Tex

PARENTS
NAME OF FATHER Geo. Allen
BIRTHPLACE OF FATHER (City or town, State or foreign country) Alabama
MAIDEN NAME OF MOTHER Annie Rosenthal
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Atlanta Ga.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. L. D. Zuercher
(ADDRESS) 1325 Lyon St.

Filed Oct 6, 1914 p. H. Gould REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Oct 5
(Month) (Day) (Year) 1914

I HEREBY CERTIFY, that I attended deceased from Sept 30, 1914 to Oct 5, 1914, that I last saw him alive on Oct 5, 1914 and that death occurred, on the date stated above, at 4:55 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Duration) ___ yrs. ___ mos. 6 ds.

Contributory (SECONDARY)
(Duration) ___ yrs. ___ mos. ___ ds.
(Signed) O. T. [Signature] M. D.
Oct 6, 1914 (Address) 1375 [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 Waco Texas DATE OF BURIAL Oct 8, 1914
UNDERTAKER [Signature] ADDRESS [Address]

RECORD OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should give

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, Sarcoma*, 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 "*Assthenia*," "*Anaemia*" (merely symptomatic), "*Atrophy*," "*Collapse*," "*Coma*," "*Convulsions*," "*Debility*" ("*Con-genital*," "*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.)

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

PLACE OF DEATH

County Wells
Clay
 Township _____
 or _____
 Village _____
 or _____
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 728 File No. _____
 Primary Registration District No. 5461 Registered No. 61

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

FULL NAME Asceola O Allen

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX m COLOR OR RACE B SINGLE MARRIED WIDOWED OR DIVORCED S
(If wife the word)

DATE OF DEATH act 5, 1914
(Month) (Day) (Year)

DATE OF BIRTH _____, 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 4:55 m.

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.

CAUSE OF DEATH* was as follows:

OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____

Orbital haemorrhage

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

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

NAME OF FATHER _____

Contributory Chronic Nephritis (interstitial)
probably several yrs (2 or 3 yrs)
 (Duration) _____ yrs. _____ mos. _____ ds.

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

(Signed) D. L. Green M. D.

MAIDEN NAME OF MOTHER _____

at 6, 1914 (Address)

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

(ADDRESS) _____

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 _____

Filed act 6 1914 J. H. Gould REGISTRAR

PLACE OF BURIAL OR REMOVAL _____ DATE OF BURIAL _____ 191____

UNDERTAKER _____ ADDRESS _____

OCT 1914

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION, PHYSICIAN, and EXACTLY stated EXACTLY. Exact statement of OCCUPATION, PHYSICIAN, and EXACTLY stated EXACTLY.

Satisfactory Information supplied

SUPPLEMENTARY INFORMATION SUPPLIED

Revised United States Standard Certificate of Death

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

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