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

28562

PLACE OF DEATH

County Marion

Township Union

or Village ~~Philadelphia~~

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

Registration District No. 549 File No. .....

Primary Registration District No. 5742 Registered No. .....

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

FULL NAME Herman Lee Allen

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

DATE OF BIRTH January 28, 1902 (Month) (Day) (Year)

AGE 14 yrs. 5 mos. 15 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

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

PARENTS
NAME OF FATHER Joseph W Allen
BIRTHPLACE OF FATHER (City or town, State or foreign country) Marion Co Mo
MAIDEN NAME OF MOTHER Myrtle Hopkins
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Marion Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Allen

(ADDRESS) Philadelphia Mo

Filed Aug 9, 1916 C. F. Tipton REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 13th, 1916 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 22, 1916, to July 13, 1916, that I last saw him alive on July 12, 1916, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

01

(Duration) ..... yrs. ..... mos. 28 ds.

Contributory (SECONDARY) .....

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

(Signed) C. W. Hawlin M. D.

July 13, 1916 (Address) Philadelphia 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 Philadelphia Mo

DATE OF BURIAL July 14, 1916

UNDERTAKER O. D. Johnson

ADDRESS Philad Mo

N. B.—Every (1) 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.

O DATE OF BIRTH ..... 1 ..... 17 I HEREBY CERTIFY, that I attended deceased from ..... 191 ..... to 191

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALT
BUREAU OF VITAL STATISTICS
CERTIFICATE 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 i hospital or institut give its NAME inst 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

..... (Month) ..... (Day), 1..... (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...., ...
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MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) ..... (Day), 191.. (Ye

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that I last saw h..... alive on ....., 191..

and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH* was as follows:

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

Contributory .....
(SECONDARY)

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

(Signed) ..... M.

....., 191..... (Address) .....

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

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

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. .....

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
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