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.

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

PLACE OF DEATH

County Lawrence

Township ..... or Village ..... or City Peirce City Mo (No. ..... St.; ..... Ward)

Registration District No. 471 File No. 11129

Primary Registration District No. 16284 Registered No. 164

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

FULL NAME Lewis L. L. Allen

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): widowed

DATE OF BIRTH: Aug 31 (Month) (Day), 1825 (Year)

AGE: 91 yrs. 6 mos. 8 ds. If LESS than 1 day, ... hrs. or ..... min.?

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

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

PARENTS

NAME OF FATHER: Barnabas Allen

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

MAIDEN NAME OF MOTHER: Emily Lavernia

BIRTHPLACE OF MOTHER (City or town, State or foreign country): St Louis County

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L L Allen

(ADDRESS) Peirce City Mo

Filed 3-9-, 1917. J E Banchell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: March (Month) 8 (Day), 1917 (Year)

I HEREBY CERTIFY, that I attended deceased from Nov 1, 1917, to March 8, 1917, that I last saw him alive on March 8, 1917, and that death occurred, on the date stated above, at 4:27 P.m.

The CAUSE OF DEATH* was as follows:

Acute Catarrhal Gastritis

10 [illegible] 118C

..... (Duration) ..... yrs. 4 mos. — ds.

Contributory (SECONDARY) .....

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

(Signed) E B Wright M. D.

March 9, 1917 (Address) Peirce City, 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: Peirce City Mo

DATE OF BURIAL: March 11, 1917

UNDERTAKER: John Seufert

ADDRESS: Peirce City Mo

Revised United States Standard Certificate of Death

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

"Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough;*

MISSOURI STATE BOARD
BUREAU OF VITAL STA
CERTIFICATE OF DEA

PLACE OF DEATH

County.....

Township ..... Registration District No..... File No.....
or
Village..... Primary Registration District No..... Registered No.....
or
City ..... (NO. ..... St.; ..... Ward)

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 DE

DATE OF DEATH

.....
(Month)

I HEREBY CERTIFY, that I atte

....., 191....., to.....

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

and that death occurred, on the date stated

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

Contributory.....
(SECONDARY)
.....(Duration).....yrs.

(Signed).....

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

*State the Disease Causing Death, or, in deaths fro (1) Means of Injury; and (2) whether Accidental, Suicidal, or

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITU RECENT RESIDENTS)

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

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

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL

DAT

UNDERTAKER

ADD