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. See instructions on back of Certificate.

1 PLACE OF DEATH

County Barry

Township White River

Inc. Town

City

STATE OF ~~ARKANSAS~~ Missouri

STATE BOARD OF HEALTH

Bureau of Vital Statistics

CERTIFICATE OF DEATH

Registration District No. 8054

Primary Registration District No. 38

File No. 34213

Registered No.

(No. ______, ______ St.; ______ Ward)

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

2 FULL NAME Goldie Allen

PERSONAL AND STATISTICAL PARTICULARS	
3. SEX: Female	4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)	
6. DATE OF BIRTH: Sept 23, 1917 (Month, Day, Year)	
7. AGE: ___ yrs. ___ mos. 16 ds.	If LESS than 1 day, ___ hrs. or ___ min?
8. OCCUPATION (a) Trade, profession, or particular kind of work	
(b) General nature of industry, business, or establishment in which employed (or employer)	
9. BIRTHPLACE (State or Country): Barry Co, Mo	
PARENTS 10. NAME OF FATHER: Henry Allen	
11. BIRTHPLACE OF FATHER (State or Country): Missouri	
12. MAIDEN NAME OF MOTHER: Belle Stamps	
13. BIRTHPLACE OF MOTHER (State or Country): Arkansas	

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Allen

(Address) Golden Mo

15. Filed Oct-10 1917 M H Roberts, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 9, 1917 (Month, Day, Year)

17 I HEREBY CERTIFY That I attended the deceased from Oct 4, 1917, to Oct 9, 1917, that I last saw her alive on Oct, 1917, and that death occurred on the date stated above, at 11 m.

The CAUSE OF DEATH * was as follows:

Paralysis Due to Spina Bifida

157R

82D 150

(Duration) ___ yrs. ___ mos. 16 ds.

Contributory (SECONDARY)

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

(Signed) J R Reynolds, M. D.

10/10, 1917 Address Greenview Ark

*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. 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

19. PLACE OF BURIAL OR REMOVAL: Viney

DATE OF BURIAL ~~REMOVAL~~ ______, 191__

20. UNDERTAKER: Frank Allen

ADDRESS

Form V. S. No. 4—50M—5-1-17.

REV STAT[illegible] TANDARD CERTIFICATE OF DEATH

(Appro[illegible] Censu[illegible] t 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, Compositor, 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 of 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 *septichaemia*, "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATH state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL 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 statements of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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.

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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

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

1 PLACE OF DEATH

County Barry

Township White River or Village or City (NO. St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Registration District No. 3054 File No.

Primary Registration District No. 38 Registered No.

2 FULL NAME Goldie Allen

SUPPLEMENTARY

Satisfactory Information Supplied

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3 SEX / 4 COLOR OR RACE / 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)	16 DATE OF DEATH Oct - 9 (Month) (Day), 1917 (Year)
6 DATE OF BIRTH (Month) (Day), 1 (Year)	17 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.
7 AGE yrs. mos. ds. If LESS than 1 day, hrs. or min.?	The CAUSE OF DEATH* was as follows: (Duration) yrs. mos. ds.
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)	CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
9 BIRTHPLACE (City or town, State or foreign country)	(Signed) M. D. , 191 (Address)
PARENTS — 10 NAME OF FATHER	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
11 BIRTHPLACE OF FATHER (City or town, State or foreign country)	18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
12 MAIDEN NAME OF MOTHER	At place of death yrs. mos. ds. In the State yrs. mos. ds.
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)	Where was disease contracted if not at place of death?
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) (Address)	Former or usual residence
15	19 PLACE OF BURIAL OR REMOVAL McGuire Graveyard — DATE OF BURIAL Oct. 9 1917
Filed Oct 18 1917 M. H. Roberts Registrar	20 UNDERTAKER Frank Allen — ADDRESS Golden Mo

Original file, date Oct 9, 1917 All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

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

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