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.

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

File No. 22197

PLACE OF DEATH

County Stone

Township Washington or Village ____ or City ____

Registration District No. 843

Primary Registration District No. 6106

Registered No. ____

(No. ____ St.; ____ Ward)

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

FULL NAME Freddie Dale Allen

PERSONAL AND STATISTICAL PARTICULARS

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

DATE OF BIRTH May 7, 1918 (Month, Day, Year)

AGE ____ yrs. 1 mos. 8 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) Stone Co. Mo.

PARENTS

NAME OF FATHER Wilford N. Allen

BIRTHPLACE OF FATHER (City or town, State or foreign country) Maries Co. Mo

MAIDEN NAME OF MOTHER Lillie M. Taylor

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Stone Co. Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wilford N. Allen

(ADDRESS) Galena Mo.

Filed 7/15 191__ G. Henson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 15th, 1918 (Month, Day, Year)

I HEREBY CERTIFY, that I attended deceased from June 10, 1918, to June 17, 1918, that I last saw him alive on June 13, 1918, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

9

0 8

(Duration) ____ yrs. ____ mos. 15 ds.

Contributory (SECONDARY) ____

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

(Signed) G. Henson M. D.

June 15 1918 (Address) Galena 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 Galena Cemetery

DATE OF BURIAL June 16, 1918

UNDERTAKER Craig Mercantile Co

ADDRESS Galena Mo

PLACE OF DEATH

County_____

Township _____
or
Village_____
or
City _____ (NO._____, _____ St.; _____ Ward)

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

Registration District No._____ File No._____

Primary Registration District No._____ Registered No._____

[If death occurred
hospital or institu
give its NAME ins
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

_____, 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 Allen

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 DEATH

DATE OF DEATH

_____, 191
(Month) (Day) (Ye

I HEREBY CERTIFY, that I attended deceased f

_____, 191____, to _____, 191

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:

_____ (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 _____, 191____
UNDERTAKER	ADDRESS