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

PLACE OF DEATH

County Wright

Township Wood 5

or Village

or City Mt Grove (NO.) (St.) (Ward)

Registration District No. 908 File No. 15468

Primary Registration District No. 6223 Registered No. 87

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

FULL NAME Bonnie Lee Allen

PERSONAL AND STATISTICAL PARTICULARS

SEX Female | COLOR OR RACE White | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Jan (Month) 26 (Day), 1920 (Year)

AGE yrs. 2 mos. 12 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) Bates Co

PARENTS

NAME OF FATHER Mat Allen

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

MAIDEN NAME OF MOTHER Phipps

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Allen

(ADDRESS) Mtn Grove Mo

Filed 3-22, 1920 J M Hubbard Asst Dep REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar (Month) 22 (Day), 1920 (Year)

I HEREBY CERTIFY, that I attended deceased from March 17, 1920, to March 22, 1920, that I last saw her alive on March 19, 1920, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Double
11963

10
(Duration) yrs. mos. ds.

Contributory Acute Indigestion
(SECONDARY)
(Duration) yrs. mos. 10 ds.

(Signed) J M Hubbard M. D.

3/27, 1920 (Address) Mt Grove 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 Fairview Cem Mtn Grove Mo | DATE OF BURIAL 3-23, 1920

UNDERTAKER N L Batton | ADDRESS Mtn Grove Mo

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
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 in a hospital or institution, give its NAME instead 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

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) (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.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

Contributory.....
(SECONDARY)

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

(Signed)..... M. D.

....., 191.... (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	DATE OF BURIAL ....., 191....
UNDERTAKER	ADDRESS

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.