

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

Do not use this space.

28292

1. PLACE OF DEATH

County Buchanan
Township St. Joseph,
City St. Joseph,

Registration District No. 35
Primary Registration District No. 1001
(No. 1015 Faraon Street.)

File No. 1067
Registered No. 1067
St. Word

2. FULL NAME Emaline Allen,

(a) Residence. No. 1015 Faraon
(Usual place of abode)

St. Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed,

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Samuel S. Allen

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 27, 1837

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

87

2

15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

At Home,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Knox County,

(STATE OR COUNTRY)

Ohio.

10. NAME OF FATHER

Abraham Dillon,

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Unknown,

(STATE OR COUNTRY)

Pennsylvania

12. MAIDEN NAME OF MOTHER

Catherine Eisenminger

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Unknown,

(STATE OR COUNTRY)

Pennsylvania,

14.

INFORMANT

Lee S. Dillon

(Address)

Wathena, Kansas.

15.

OCT 13, 1924

Ezra Harrison

REGISTRAR

15. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 17th. 1924

I HEREBY CERTIFY, That I attended deceased from Oct 11, 1924, to Oct 12th, 1924, that I last saw deceased alive on OCT 12, 1924, and that death occurred, on the date stated above, at 2:55 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Indigestion

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.

(DID AN OPERATION PRECEDE DEATH? No DATE OF NO)

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS. Clinical symptoms

(Signed) H. W. Weston, M. D.

Oct 13, 1924 (Address) Logan Bldg St. Joseph Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Mount Mora Cemetery

Oct. 14, 1924

20. UNDERTAKER

ADDRESS

Heaton-Bigelow Und. Co.

319 S. 10th. St

E. J. H. Kase.

Revised United States Standard Certificate of Death

(Approved by U. S. Census and 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, Composer, 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, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of———(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasm); *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 or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or 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 statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

NOTE.—Individual offices may add to above list of undesirable terms and refuse to accept certificates containing them. Thus the form in use in New York City states: "Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death: Abortion, cellulitis, childbirth, convulsions, hemorrhage, gangrene, gastritis, erysipelas, meningitis, miscarriage, necrosis, peritonitis, phlebitis, pyemia, septicemia, tetanus." But general adoption of the minimum list suggested will work vast improvement, and its scope can be extended at a later date.

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County BuchananRegistration District No. 83

File No. _____

Township _____

Primary Registration District No. 1001Registered No. 1067City St. Joseph (No. _____)

St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

W

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

PARENTS

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT

(Address)

15.

FILED

12/19/24 Edna Harrison REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct-12-1924

17.

I HEREBY CERTIFY, That I attended deceased from Oct 11, 1924, to Oct 12, 1924, that I last saw h. Oct 11, at Oct 12, 1924, and that death occurred, on the date stated above, at Oct 3 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute indigestion
following eating eggs
Ches. fried onions & cabbage
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) of emphysema & debility

(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH?

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS Clinical symptoms(Signed) Wm. H. H. H. H. M. D.Nov 26, 1924 (Address) St. Joseph Mo.

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

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