

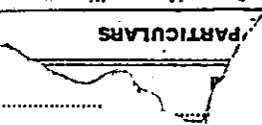
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

3500

1 PLACE OF DEATH

County *Adair*



Township Registration District No. *4* File No.
or
Village Primary Registration District No. *3001* Registered No. *18*
or
City *Kirksville* (NO. St. Ward)

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

2 FULL NAME *Robert L. Allen*

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE MARRIED WIDOWED OR DIVORCED *Widowed*
(Write the word)

6 DATE OF BIRTH *Feb. 17- 1841*
(Month) (Day) (Year)

7 AGE *83- yrs 11- mos 17- ds.* If LESS than 1 day.....hrs. or.....min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work *Farmer Retired*
(b) General nature of industry business, or establishment in which employed (or employer) *Gen Farming*

9 BIRTHPLACE (City or town, State or foreign country) *U.S.*

PARENTS
10 NAME OF FATHER *Benjamin Allen*
11 BIRTHPLACE OF FATHER (City or town, State or foreign country) *U.S.*
12 MAIDEN NAME OF MOTHER *Elizabeth Fry*
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) *U.S.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Mrs. Shumaker*
(Address) *Kirksville Mo*

15 Filed *2 2*, 19*25*. *AWB*
Registrar

7 MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Feb. 2- 1925*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from *Sept 1, 1924* to *Feb 2, 1925* that I last saw him *alive on Dec 10, 1924* and that death occurred, on the date stated above, at *12:15 A.M.*

The CAUSE OF DEATH* was as follows:
Old age sub symptoms was
obstruction of
stomach (Duration) *44* yrs. mos. ds.

CONTRIBUTORY (Secondary) *44* (Duration) yrs. mos. ds.
(Signed) *J. J. Parmentier* M. D.
Feb 2, 1925 (Address) *Kirksville Mo*

*State the Disease Causing Death, or, in deaths 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 *Shumaker Cem* DATE OF BURIAL *Feb. 4, 1925*

20 UNDERTAKER *S. J. McDavitt* ADDRESS *Elmer Mo.*

