

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

Do not use this space.

**1. PLACE OF DEATH**

County.....

Registration District No.....

791

34720

Township.....

Primary Registration District No.....

1003

File No.....

City *St Louis Mo*

(*Mo Pacific*)

*1755 Grand Blvd*

Registered No. *10720*

St.....

Ward.....

**2. FULL NAME**

(a) Residence, No. *2630 Russell Ave*

(Usual place of abode)

St. *3*

Ward.....

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.

(If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX

*Male*

4. COLOR OR RACE

*White*

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

*Married*

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

*Jennie Allyn*

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

*Aug 23<sup>rd</sup>, 1840*

7. AGE

YEARS *85*

MONTHS *2*

DATE *22*

IF LESS than 1 day, ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

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

*Black*

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

*Mo Pac R.R.*

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

*Ohio*

10. NAME OF FATHER

*John M. Allyn*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Corn.*

12. MAIDEN NAME OF MOTHER

*Emily Comstock*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Corn.*

14.

INFORMANT (Address)

*Mrs Jennie Allyn 2630 Russell Ave*

15.

FILED

*17 1925*

*Maub Starhoff*

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR)

*Nov. 15 1925*

17.

I HEREBY CERTIFY, That I attended deceased from *8 1/2* *Nov* 19*25*, to *Nov 15* 19*25*, that last saw him alive on *Nov 15* 19*25*, and that death occurred, on the date stated above, at *9 1/2 A* m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

- acute dilatation of heart*
- arterial sclerosis*
- senility*

CONTRIBUTORY (SECONDARY)

*spontaneous hemorrhage of brain* (duration) yrs. *5* mos. *14* ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? *no* DATE OF *Nov 15, 25*

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical*

(Signed) *L. Wientz*

M. D.

*11/15*, 19*25* (Address) *Mo. Pac. Hoop. St Louis*

\*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

*Riggston, Ills.*

DATE OF BURIAL

*11/18/ 1925*

20. UNDERTAKER

*C.R. Ruppert*

ADDRESS

*4449 Olive, St. Louis*

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

# 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, 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*; *Broncho-pneumonia* ("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.; *Broncho-pneumonia* (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, plebitis, 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.

cated by check marks, lacking from the death certificate

Name: John M. Allen

Who died at: St. Louis City on Nov, 15-1925

Residence: No. \_\_\_\_\_ St. \_\_\_\_\_

(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Sex: \_\_\_\_\_ Color or race: \_\_\_\_\_ Single, married, widowed or divorced: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Occupation: (a) Trade \_\_\_\_\_ (b) Industry: \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

Contributory: Operation for Hematoma of Hip non Traumatic  
cause unknown. Information given over Phone by Ser.

Where was disease contracted? L. Wentzel 4-14-26 - Div. of P.S.

Did operation precede death? yes Date of \_\_\_\_\_

Was there an autopsy? \_\_\_\_\_ What test confirmed diagnosis? 50 B

Name of physician: \_\_\_\_\_

Address of physician: \_\_\_\_\_

5470