

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

Do not use this space.

18027

1. PLACE OF DEATH

County Lrene Registration District No. 318

Township Springfield Primary Registration District No. 2001

City Springfield (No. 1615 1/2) N. Campbell St. 375 (Ward)

2. FULL NAME

(a) Residence. No. 1615 1/2 N. Campbell 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 10 - 1856

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 70 | 6 | 9

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home 891
(b) General nature of industry, business, or establishment in which employed (or employer) 1191
(c) Name of employer 160

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Elias M. Allen

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ky.

12. MAIDEN NAME OF MOTHER Etiza J. Shelton

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ill.

14. INFORMANT (Address) Mrs. Mary E. Allen
Springfield Mo

15. FILED 6/20/27 O. C. Horst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 19 1927

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1927 to June 18 1927 that I last saw him alive on June 18 1927, and that death occurred, on the date stated above, at 7:52 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Hemiplegia - results general loss of vitality
(duration) 3 yrs. mos. da.

CONTRIBUTORY (SECONDARY) Acute Indigestion
One week (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptoms
(Signed) Salomon M. Doble M. D.

6/19. 1927 (Address) Springfield 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Maple Park Cemetery June 20 27

20. UNDERTAKER ADDRESS
W. K. King & Co. 424 1/2 Comm St
Springfield Mo

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.

WHEN UNFOLDING INK—THIS IS A PERMANENT RECORD

JUL 26 1927

