

SEP 27 1927

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

23996

1. PLACE OF DEATH

County DekalbRegistration District No. 259Township CamdenPrimary Registration District No. 4128City Maysville (No.)

File No.

Registered No.

St. Ward)

2. FULL NAME Mary Wilmagena Allen

(a) Residence. No. St.

(Usual place of abode)

Ward.

(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

4. COLOR OR RACE

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

F.Wh.Infant

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

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

Aug 27th 1925

7. AGE

YEARS

MONTHS

DAYS

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

1116

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)

Dekalb Co.

(STATE OR COUNTRY)

Mo.

10. NAME OF FATHER

Lincoln Allen

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

Frankie Casper

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

14.

INFORMANT

Mrs. Clyde Long

(Address)

Maysville

15.

FILED

Aug 4, 1927

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 3, 1927.

17.

I HEREBY CERTIFY That I attended deceased from August 3, 1927 to August 3, 1927 that I last saw her alive on August 3, 1927, and that death occurred, on the date stated above, at 11:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cranial fracture2:07 PM(duration) 10 hours. mos. da.

CONTRIBUTORY

(SECONDARY)

(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

8 DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) [Signature] M. D.8/3, 1927 (Address) Maysville, 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

Oak Grove Cem. Dekalb8/4/27

20. UNDERTAKER

ADDRESS

U. G. PilcherMaysville

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.

CAUSE OF DEATH in this form. It may be properly classified. AGE 8, -

(Handwritten signatures and initials)

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Louis

Township Mayville

City Mayville (No.)

Registration District No. 259

Primary Registration District No. 4158

File No.

Registered No.

St.

Ward)

2. FULL NAME

(a) Residence. No.

(Usual place of abode)

St.

Ward.

(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

F

4. COLOR OR RACE

W

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

S

**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

**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 Aug 4, 1927

SUPPLEMENT

MEDICAL CERTIFICATE OF DEATH

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

Aug 3 1927

17.

I HEREBY CERTIFY That I attended deceased from, 19....

that I last saw h. alive on, 19...., and that
death occurred, on the date stated above, at m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Crushed fracture
Child's head on R.R. right down
from pitman to accident
about 1/4 mile east of
Mayville Depot. Support
had struck wing fence
on cattle guard.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH

DATE OF

WAS THERE AN AUTOPSY

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

10/23, 1927

(Address)

Mayville, 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

19

20. UNDERTAKER

ADDRESS

REGISTRAR

REGISTRATION SHALL BE
MADE BY THE
CAUSE
OF DEATH
IN THE
STATE OF
MISSOURI
SHOULD BE
STATED EXACTLY.
PHYSICIANS SHOULD STATE
EXACT STATEMENT OF OCCUPATION
IS VERY IMPORTANT.
THEY ARE COMPLETE AS PRESCRIBED BY LAW

23996