

PR 23 1928

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

7936

1. PLACE OF DEATH

County BuchananRegistration District No. 85

Township

Primary Registration District No. 1001

City

St. Joseph,(No. Missouri Methodist Hospital)File No. 313Registered No. 313

St.

Ward)

2. FULL NAME

Nellie G. Allen,

(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. 1mos. 12

da. _____

How long in U.S., if of foreign birth?

yrs. _____

mos. _____

da. _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

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 OFClato B. Allen,

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

March 21, 1885

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, _____ hrs.
or _____ min.4303

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)

Whitesville,

(STATE OR COUNTRY)

Missouri,

10. NAME OF FATHER

Columbus Hobson,

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Unknown,

(STATE OR COUNTRY)

Unknown,

12. MAIDEN NAME OF MOTHER

Adelia Harlan,

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Unknown,

(STATE OR COUNTRY)

Ohio,

14.

INFORMANT

Clato B. Allen
Address) Stanberry, Missouri.

15.

FILED

26 1928

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

March 24, 1928

17.

I HEREBY CERTIFY, That I attended deceased from March 24, 1928, to March 24, 1928
that I last saw him alive on March 23, 1928, and that
death occurred, on the date stated above, at 7:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Embolism
543
111A
(duration) _____ yrs. _____ mos. 1 da.

CONTRIBUTORY
(SECONDARY)

Tuberculosis
(duration) 2 yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH?

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)

Address)

*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

Stanberry, Missouri Auto

DATE OF BURIAL

March 26th 1928

20. UNDERTAKER

ADDRESS

Heaton-Balch & Co. 319 S. 10 St.
St. Joseph, 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.

JAN 11 1950

**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 Buchanan
Township St Joseph
City St Joseph (No.)

Registration District No. 85-
Primary Registration District No. 1001

File No.
Registered No. 383
St. Ward)

2. FULL NAME

(a) Residence. No. St. Ward.
(Usual place of abode)

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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

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 Mar 28 1928 John Gatz REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 24 1928

17. I HEREBY CERTIFY, That I attended deceased from, 19...., to, 19...., that I last saw him alive on, 19...., and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Embolism

CONTRIBUTORY (SECONDARY) Fibroid uterus (Non-Malignant)

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) M. D. , 19 (Address)

*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

20. UNDERTAKER

ADDRESS

THIS SUPPLEMENTARY STATEMENT OF OCCUPATION IS IMPORTANT. PHYSICAL STATEMENT OF OCCUPATION IS IMPORTANT. ARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW. IF

5-2936