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

Do not use this space.

8182

1. PLACE OF DEATH

County: Cass — Registration District No.: 156 — File No.:

Township: Peculiar — Primary Registration District No.: 5220 — Registered No.: 23

City: ..... (No. ..... St. ..... Ward)

2. FULL NAME America Catherine Allen

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

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 OF: John W Allen

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 22 1863

7. AGE: Years 65 — Months 8 — Days 25 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(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): Illinois

PARENTS

10. NAME OF FATHER: William Digby
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Illinois
12. MAIDEN NAME OF MOTHER: Mary West
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Illinois

14. INFORMANT: x Maud Arnold
(Address): Freeman, Mo. R.2

15. FILED: 3/19 1928 D Long — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 3/17 1928

17. HEREBY CERTIFY, That I attended deceased from Mch. 11 1928 to Mch. 17 1928, that I last saw h. m. alive on Mch. 17 1928, and that death occurred, on the date stated above, at 11:55 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho pneumonia
10 [illegible]
[illegible]
(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (SECONDARY): Asthma
(duration) 6 yrs. — mos. — ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
O DID AN OPERATION PRECEDE DEATH? no DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? —

(Signed) J. S. Triplett M.D
3/17, 1928 (Address) Harrisonville, 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: Wills Cemetery — DATE OF BURIAL: 3/19 1928

20. UNDERTAKER: Rummenberger Bros Co — ADDRESS: Harrisonville

CAUSE OF DEAT[illegible] should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shou[illegible] terms, so that it may be properly classified. Exact statement of OCCUPATION is very impo[illegible]

64 —

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Cass — Registration District No. 156 — File No.

Township Peculiar — Primary Registration District No. 5220 — Registered No. 23

City ..... (No. ..... St. ..... Ward)

2. FULL NAME America Catherine 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. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 22 - 1863

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	64	8	25	

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)

PARENTS

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 7/19 1928 D Stong
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3 - 17 1928

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 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:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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

REGISTRAR ... RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY ... AW

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