WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

MAY 30 1928

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County Barry

Township White River — Registration District No. 38 — File No. 16060

or Village ~~[illegible]~~ — Primary Registration District No. 5054 — Registered No.

or City (NO. St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Samuel Allen

PERSONAL AND STATISTICAL PARTICULARS	
3 SEX	Male
4 COLOR OR RACE	White
5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)	Widowed
6 DATE OF BIRTH	Apr (Month) 12 (Day) 1847 (Year)
7 AGE	81 yrs. 1 mos. 14 ds. — If LESS than 1 day, ...hrs. or ......min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work	Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)	
9 BIRTHPLACE (City or town, State or foreign country)	Tennessee
PARENTS: 10 NAME OF FATHER	Hezekiah Allen
11 BIRTHPLACE OF FATHER (City or town, State or foreign country)	Tenn
12 MAIDEN NAME OF MOTHER	Jennie Glover
13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)	Tenn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Kidey Allen

(Address) Galden, Mo

15 Filed 5/28 1928 Emma Weddington Registrar

MEDICAL CERTIFICATE OF DEATH	
16 DATE OF DEATH	May (Month) 26 (Day) 1928 (Year)

17 I HEREBY CERTIFY, that I attended deceased from May 24, 1928, to May 26, 1928, that I last saw him alive on May 26, 1928, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Labor

11 P
198
11 P

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) x yrs. x mos. 14 ds.

(Signed) E. L. Phillips M. D.

May 27, 1928 (Address) Galden Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ......yrs. ......mos. ......ds. In the State ......yrs. ......mos. ......ds.

Where was disease contracted if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL McGuire Mo — DATE OF BURIAL 5/27 1928

20 UNDERTAKER L. Willyard — ADDRESS Golden Mo.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ....., 1..... (Day) ..... (Year)

7 AGE ..... yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

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

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day) ....., 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,

that I last saw h..... alive on ....., 191.....,

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.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS