FEB 22 1929

49
17
7

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

Do not use this space.

Mar. 2079

1. PLACE OF DEATH

County Jasper — Registration District No. 417 — File No.

Township — Primary Registration District No. 3021 — Registered No. 5

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

2. FULL NAME Allen F. Mote

(a) Residence. No. 828 S Hall 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)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 30 1857

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	71	9	6	

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

34

9. BIRTHPLACE (CITY OR TOWN) Dayton
(STATE OR COUNTRY) Ohio

2

PARENTS

10. NAME OF FATHER Wm Mote

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

2

12. MAIDEN NAME OF MOTHER Unknown

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

31

14. INFORMANT Lucy B. Mote
(Address) Webb City Mo

15. FILED 1/9, 1929 R. M. Stormont
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 5, 19 ..

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 12:00 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial Nephritis

131 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 129a

(duration) yrs. mos. ds.

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) W. W. Waggoner, M. D
, 19 (Address) Webb City 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
Mount Hope Cem	1/8 1929
20. UNDERTAKER	**ADDRESS**
Webb City Und Co	Webb City

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.