

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

Do not use this space.

41523-a

1. PLACE OF DEATH

County San Madrid
Township Parma
City Parma (No.)

Registration District No. 605
Primary Registration District No. 4359

File No.
Registered No.
St. Ward)

2. FULL NAME

Louise E. Allen

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

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 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

Clyda Mae Allen

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 29-1899

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or min.
37 1 21

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Illinois
(STATE OR COUNTRY)

10. NAME OF FATHER J. B. Allen

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

12. MAIDEN NAME OF MOTHER Martina E. Allen

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

14. INFORMANT Clyda Allen
(Address) Parma Mo

15. FILED Feb 21, 1929 Mrs C.S. Blackman
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/20 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 23rd, 1929, to Dec 20, 1929, that I last saw him alive on Dec 13th, 1929, and that death occurred, on the date stated above, at 3:10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Edema of Lungs

CONTRIBUTORY (SECONDARY) Spinal Paralysis
arterio-sclerosis (duration) 1 yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, ...

DID AN OPERATION PRECEDE DEATH? yes DATE OF Feb. 1929

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) L. M. Davis, M. D.
, 19 (Address) Parma 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

Berlinia Mo. 12/21 1929

20. UNDERTAKER L. M. Davis ADDRESS Parma Mo

N. B.—Every item of information should be carefully supplied. AGE and SEX must be stated. STATEMENT OF OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

This Physician has moved
away. I think the
tumor was on the spine.

Was this Tumor
malignant?

Also, please, state
where Tumor was
located in body.

**ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.**

WRITE PLAINLY, WITH UNFADING INK. THIS IS A REQUIREMENT.

ARE COMPLETE AS PRESCRIBED BY LAW

NO A FEE FOR CERTIFICATES UN

REGISTRARS

1. PLACE OF DEATH.

AGE OF DEATH. _____
 County New Madrid Registration District No. 6005 File No. _____
 Township _____ Primary Registration District No. 4359 Registered No. _____
 City Osage (No. _____) St. _____ Ward _____

2. FULL NAME

(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	yrs.	mos.	ds.	How long in U.S., if of foreign birth?	yrs.	mos.	ds.

PERSONAL AND STATISTICAL PARTICULARS

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

415.

FILED 12/29 1929 Mrs C. S. Blackman REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/20 1929

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:

CONTRIBUTORY (SECONDARY) *Spinal Paralysis*

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