

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

Do not use this space.

9487

File No. _____
Registered No. 60
St. _____ Ward _____

1. PLACE OF DEATH

County Marion Registration District No. 547
Township Masson Primary Registration District No. 3029
City Hannibal (No. 911) Wabash

2. FULL NAME

George Allen
(a) Residence No. 911 Wabash St. _____ Ward _____
(Residence 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 <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Sarah</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>--- -- 1865</u>		
7. AGE <u>about 65</u>	YEARS --	MONTHS --
	DAYS --	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer). (c) Name of employer.		
9. BIRTHPLACE (CITY OR TOWN) <u>Canon</u> (STATE OR COUNTRY) <u>mo</u>		
PARENTS	10. NAME OF FATHER <u>Zeasle Allen</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>mo</u>	
	12. MAIDEN NAME OF MOTHER <u>Sarah Allen</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) <u>mo</u>	
14. INFORMANT <u>Sarah Strake</u> (Address) <u>Hannibal mo</u>		
15. FILED <u>3/8 30</u> <u>O. Blouin</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/3/1930

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 _____ 3 30 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocarditis
1930

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

CONTRIBUTORY (SECONDARY) Industrial Acc.
_____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRIBUTED?
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. J. Ferrell, M. D.
19 _____ (Address) Hannibal, 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 Baptist Cemetery DATE OF BURIAL 3/6 1930

20. UNDERTAKER James O'Donnell ADDRESS Hannibal mo

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.

APR 30 1930

