

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

Do not use this space.

18314

1. PLACE OF DEATH

County Scott
Township Peachland
City Marion, Mo.

Registration District No. 831
Primary Registration District No. 6070

File No. 29
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Washington Elay 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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb - 22 - 1930

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 2 14

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 182
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Marion
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER Melvin Allen

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

12. MAIDEN NAME OF MOTHER Fern Stevens

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

14. INFORMANT Fern Allen
(Address) Marion, Mo.

15. FILE 6/9/30 Walter E. Davis
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-5-30 19

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

accidentally mangled
by covers while sleeping
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 180
(duration) _____ yrs. _____ mos. _____ ds.

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? 3

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) George B. Dwyer, M. D.
, 19____ (Address) Coroner's Court

*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

Carpenter cemetery 5-6-30
20. UNDERTAKER George R. Dwyer
ADDRESS Marion, Mo.

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY.

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