

OCT 30 1930

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County Macon
 Township Willefort
 City Willefort (No. _____)

Registration District No. 533
 Primary Registration District No. 5719

File No. 30479
 Registered No. _____
 St. _____ Ward _____

2. FULL NAME

George Henry 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)

single

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

✓

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

Sept 17-1929

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
 day, _____ hrs.
 or _____ min.

1—3

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)

Macon Co. Mo

10. NAME OF FATHER

Henry Allen

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Macon Co Mo

12. MAIDEN NAME OF MOTHER

Violet Sutton

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Macon Co Mo

14.

INFORMANT

(Address)

George Allen
Ex parte Mo (P.I.)

15.

FILED

19

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-20-193017. I HEREBY CERTIFY, That I attended deceased from 9-20-30

19 _____ to 9-20-30 1930
 that I last saw him alive on 9-20-30 1930 and that
 death occurred, on the date stated above, at 8:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Infarction of the heart
11:30
6:30 (duration) 1 yrs. 10 mos. 10 ds.
 CONTRIBUTORY Infarction from heart
 (SECONDARY) (duration) 1 yrs. 10 mos. 10 ds.

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)

Macon

*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

Howard Ave.9-21-1930

20. UNDERTAKER

ADDRESS

Stephen L. LaddMacon Mo

N. E. B. should state CAUSE of death. AGE should be carefully supplied. AGE should be so that it may be properly classified.

to blue

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THIS IS A PERMANENT RECORD

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Macon Registration District No. 335- File No. 129
Township Middlefork Primary Registration District No. 3719 Registered No. 129
City Macon (No.) St. Ward

2. FULL NAME

(a) Residence. No. St. Ward.
(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) S

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 17-1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 — 3

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) Macon Co Mo

10. NAME OF FATHER Henry Allen

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

12. MAIDEN NAME OF MOTHER Essie Sutton

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

14. INFORMANT Henry Allen
(Address) Excella Mo (R)

15. Sept 1930 J. J. King REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/20 1930

17. I HEREBY CERTIFY That I attended deceased from 9-20 1930 to 9-20 1930, and that that I last saw him alive on 9-20 1930, and that death occurred, on the date stated above, at 8:30 m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Toxemia or Cholera

CONTRIBUTORY (SECONDARY) Infection from milk
(duration) 1 yrs. 10 mos. 0 ds.

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) A. M. Raines, M. D.
, 19 (Address) macon 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 Howard Cem. DATE OF BURIAL 9-21 1930

20. UNDERTAKER Stephens & Gooding ADDRESS macon mo

Every item of information should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-30479