

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

Do not use this space.

2374

PLACE OF DEATH

County Pettis

Registration District No. 668

Township Sedalia

Primary Registration District No. 3032

City Sedalia (No.)

File No.
Registered No. 10
St. Ward)

2. FULL NAME William Harvey Allen

(a) Residence. No. 1715 East 2^d St., 3 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 8-1953

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 8 11

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) Self
(c) Name of employer

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

10. NAME OF FATHER William Allen

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Do not know

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Do not know

14. INFORMANT (Address) Julia Hamby
Sedalia Mo

15. FILED 1-8-31 19 31
J. J. Love
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 7 1931

17. I HEREBY CERTIFY, That I attended deceased from Jan 4 1931, to Jan 7 1931, that I last saw him alive on Jan 7 1931, and that death occurred, on the date stated above, at 5:55 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute lymphangitis
10 yrs (duration) yrs. mos. 10 ds.

CONTRIBUTORY (SECONDARY) Pneumonia
(duration) yrs. mos. 4 ds.

18. WHERE WAS DISEASE CONTRACTED While working in timber
IF NOT AT PLACE OF DEATH. a small cut of left index finger.

DID AN OPERATION PRECEDE DEATH. Yes DATE OF ?

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Bacteriological examination
(Signed) W. J. Hamby M. D.
, 19 (Address) Sedalia

*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 Verita Okla DATE OF BURIAL 1/10 1931

20. UNDERTAKER McLaughlin Bros ADDRESS Sedalia

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.

FILED FEB 20 1931

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**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 Dittus Registration District No. 668 File No.
 Township Salina Primary Registration District No. 3032 Registered No. 10
 City Salina (No.) St. Ward)

2. FULL NAME William Harvey 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 M 4. COLOR OF RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 8 - 1893

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

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)

15.

FILED 19 1931

J. J. Love
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 7 1931

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

acute lymphangitis

CONTRIBUTORY lobar pneumonia (duration) yrs. mos. ds.
 SECONDARY

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

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-2577