

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.

OCT 24 1931

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

Do not use this space.

31966

1. PLACE OF DEATH

County New Madrid
Township Corn
City Paris (No.)

Registration District No. 605
Primary Registration District No. 5804

File No.
Registered No.
St. Ward)

2. FULL NAME

Sola May 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

F

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) Feb 1 1928

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, hrs.
or min.

3

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

nil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Paris

(STATE OR COUNTRY)

10. NAME OF FATHER

Samuel Allen

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo

12. MAIDEN NAME OF MOTHER

Eta Wilkins

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ill

14.

INFORMANT.
(Address)

Samuel Allen (father)
Risco, Mo.

15.

FILED

Sept 5 1931

Mrs C. S. Black
REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 5 1931

17. I HEREBY CERTIFY, That I attended deceased from August 5 1931 to Sept 5 1931
that I last saw her alive on Sept 5 1931, and that death occurred, on the date stated above, at 3:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
16 (duration) yrs. mos. ds.
CONTRIBUTORY Infantile Paralysis
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? Y DATE OF.....WAS THERE AN AUTOPSY? YWHAT TEST CONFIRMED DIAGNOSIS Chemical(Signed) Thos. H. H. H. M. D.. 19 (Address) Parma

*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

Malden, Mo

Sept 6 1931

20. UNDERTAKER

ADDRESS

J. C. Knight

Parma, Mo

**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 New Madrid
Township Como
City (No.)

Registration District No. 605
Primary Registration District No. 5-804

File No.
Registered No.
St. Ward

2. FULL NAME

Lola May 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. mes. da. How long in U.S., if of foreign birth? yrs. mes. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 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) Feb 15 1928

7. AGE YEARS MONTHS DAYS 3 6 1 If LESS than 1 day, 1 hrs. or 1 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 Sept 15 1931 Miss C. S. Blue REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/5 19 31

17. I HEREBY CERTIFY That I attended deceased from 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)
(duration) yrs. mos. da.

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

ENT RECORD

THIS IS A

UNFAIR

WRITE PLAINLY, WITH UNFAIR

TY. PHYSICIANS should be of OCCUPATION is very impo.

AGE should be classified. Exact

item of information should be carefully DEATH in plain terms, so that it may b

CA.

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

5-31964