

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

Do not use this space.

40579

1. PLACE OF DEATH *Macon* County *Macon* Registration District No. *527*
Towship *Bevier* Primary Registration District No. *5203*
City *Bevier* (No. *4912*)
2. FULL NAME *Roger Clifford Allen*
(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. (If nonresident, give city or town and State)

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 *Single*
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 3-1915*
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *17 4 25*
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *School Boy*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Hesta Mo*
13. NAME *Ray Allen*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Rayville Mo*
15. MAIDEN NAME *Mary Vestal*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Bevier Mo*
17. INFORMANT (ADDRESS) *Ray Allen Bevier Mo*
18. BURIAL, CREMATION, OR REMOVAL
PLACE *Macon* DATE *Dec 30 1932*
19. UNDERTAKER (ADDRESS) *Henry J Edwards Bevier Mo*
20. FILED *12-29 1932* *Dwight J Edwards* Registrar.

MEDICAL CERTIFICATE OF DEATH
21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 28 1932*
22. I HEREBY CERTIFY, That I attended deceased from *Dec 18 1932* to *Dec 28 1932*
I last saw him alive on *Dec 28 1932* Death is said to have occurred on the date stated above, at *4:15* p.m.
The principal cause of death and related causes of importance were as follows:
Lobar Pneumonia
Other contributory causes of importance:
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____
(Signed) *W. M. Welch* M. D.
(Address) *Callao Mo.*

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.

