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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

AUG 23 1935

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

Do not use this space.

25191

1. PLACE OF DEATH
County St. Louis
Township Carondolet
City Koch, Mo. (No. Koch, Hospital St. Ward)

Registration District No. 1123
Primary Registration District No. 6248 B

File No.
Registered No. 252

2. FULL NAME Allen Hill

(a) Residence, No. 2115a Lucas St. 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. 6 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Negro
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Lola Pitts ~~Common-law wife~~

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-22-1888

7. AGE: Years 46 | Months 8 | Days 24 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer
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 5 yrs.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Brookfield, Miss.

FATHER
13. NAME Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) ~~Koch Hospital Records~~

18. BURIAL, CREMATION, OR REMOVAL
PLACE Father Dickson DATE July 20, 1935

19. UNDERTAKER A. L. Beal Undt. Co.
(ADDRESS) 2726 Lucas Ave

20. FILED July 20, 1935 L. Mowry Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-16-35, 19

22. I HEREBY CERTIFY, That I attended deceased from 7-1-35, 19, to 7-16-35, 19

I last saw him alive on 7-16-35, 19. Death is said to have occurred on the date stated above, at 5:00 A.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary Tuberculosis FA	
Left Spontaneous	
Pneumothorax	
Left - Empyema.	
Tuberculoid Enteritis	

Other contributory causes of importance

Name of operation Date of
What test confirmed diagnosis? Sputum Was there an autopsy? Yes

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) D. H. Trumpee, M. D.
(Address) Koch, Mo.