

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.

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

Do not use this space.

SEP 18 1935

25698

1. PLACE OF DEATH

County Buchanan
Township Washington
City St. Joseph (No. Buchanan County Infirmary)

Registration District No. 82

Primary Registration District No. 5127

File No. 62

Registered No. 62

2. FULL NAME

Dave Allen

(a) Residence, No. Buchanan City Infirmary
(Usual place of abode)

Ward.

(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) Widower

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) November 10, 1843

7. AGE YEARS 91 MONTHS 9 DAYS 2 If LESS than 1 day, hrs. or min.

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

Railroad

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) unknown
(STATE OR COUNTRY) Tennessee

13. NAME Unknown Allen

14. BIRTHPLACE (CITY OR TOWN) unknown
(STATE OR COUNTRY) unknown

15. MAIDEN NAME unknown

16. BIRTHPLACE (CITY OR TOWN) unknown
(STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Buchanan County Infirmary
Reeds St. Joseph, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE City Cemetery DATE August 14, 1935

19. UNDERTAKER (ADDRESS) F. R. Sidenfaden
602 South 10th Street

20. FILED Aug 14 1935 J. J. J. J. J. Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 13, 1935

22. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1935, to Aug 13, 1935

I last saw him alive on Aug 12, 1935 Death is said to have occurred on the date stated above, at m.

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

Cerebral Apoplexy

Date of onset

5 days

Other contributory causes of importance:

Arteriosclerosis - General

male tooth

Name of operation none Date of none

What test confirmed diagnosis? none Was there an autopsy? none

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? none Date of injury none, 1935

Where did injury occur? none

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury none

Nature of injury none

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify none

(Signed) H. H. H., M. D.

(Address) 301. 1st Bldg

St. Joseph Mo

