

OCT 20 1937

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

Do not use this space.

1. PLACE OF DEATH

County *Jasper*
Township *Marshall*
City *Wagon*

Registration District No. *413*
Primary Registration District No. *5559C*

File No. *34531*
Registered No. *47*
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. *664 W. Central St.* Ward. *Carthage*
(Usual place of abode)
Length of residence in city or town where death occurred yrs. *4* mos. *18* 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) *Married*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Nov 27-1901*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
35 9 17

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

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) *Missouri*

13. NAME *James H. Allen*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

15. MAIDEN NAME *Francis Foster*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

17. INFORMANT (ADDRESS) *Records*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Port. Carthage* DATE *9/15* 19*37*

19. UNDERTAKER (ADDRESS) *Mew - Drake Carthage*

20. FILED *10/1* 19*37* *Harry A. Weaver* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Sept 13* 19*37*

22. I HEREBY CERTIFY, That I attended deceased from *Apr 26* 19*37*, to *Sept 13* 19*37*.

I last saw him alive on *Sept 13* 19*37* Death is said to have occurred on the date stated above, at *10.9* m.

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

Presecondary Tuberculosis

Other contributory causes of importance: *23*

Name of operation *None* Date of _____
What test confirmed diagnosis? *Roentgen* Was there an autopsy? *No*

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? *No*
If so, specify _____

(Signed) *Lucy E. Daugland*, M. D.
(Address) *West City*

WHITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

