

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

35  
7

PLACE OF DEATH  
County St. Louis  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
or  
City Sedalia (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 668 File No. 23583  
Primary Registration District No. 3032 Registered No. 167

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Willie Sammie Allen

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

SEX M COLOR OR RACE W SINGLE Widow  
MARRIED WIDOWED OR DIVORCED  
(Write the word)

DATE OF DEATH July 15, 1914  
(Month) (Day) (Year)

DATE OF BIRTH Jan 1, 1849  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_,

AGE 65 yrs. - mos. - ds. If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

and that death occurred, on the date stated above, at 10 m.  
The CAUSE OF DEATH\* was as follows:

OCCUPATION  
(a) Trade, profession, or particular kind of work Newspaper  
(b) General nature of industry, business, or establishment in which employed (or employer)

Chronic valvular heart disease

BIRTHPLACE (City or town, State or foreign country) Ohio

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

PARENTS NAME OF FATHER David B. Allen

Contributory (SECONDARY) (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

BIRTHPLACE OF FATHER (City or town, State or foreign country) Iowa

(Signed) D. P. Byer Coroner M. D. July 15, 1914 (Address) Sedalia Mo

MAIDEN NAME OF MOTHER Samuel Perrell

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) means of injury; and (2) whether Accidental, Suicidal, or Homicidal.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ohio

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) H. C. Staley

Where was disease contracted If not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

(ADDRESS) Sedalia

PLACE OF BURIAL OR REMOVAL Sedalia DATE OF BURIAL 7/17, 1914

Filed 7/16, 1914 H. B. Pugh REGISTRAR

UNDERTAKER Edna Mills ADDRESS Sedalia 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.

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc. of ..... (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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

PLACE OF DEATH  
*Pettus*  
County \_\_\_\_\_  
Township \_\_\_\_\_  
or  
Village \_\_\_\_\_  
City \_\_\_\_\_

Registration District No. *668* File No. \_\_\_\_\_  
Primary Registration District No. *3032* Registered No. *167*

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME *Miller Samuel Allen*

PERSONAL AND STATISTICAL PARTICULARS

SEX <i>M</i>	COLOR OR RACE <i>W</i>	SINGLE MARRIED WIDOWED OR DIVORCED <i>Widowed</i> <small>(Write the word)</small>
DATE OF BIRTH <i>1</i> (Month) <i>1</i> (Day) <i>1914</i> (Year)		
AGE <i>38</i> yrs. <i>11</i> mos. <i>15</i> ds.		IF LESS than 1 day, <i>1</i> hrs. <i>15</i> min.
OCCUPATION (a) Trade, profession, or particular kind of work <i>Satisfactory Information Supplied.</i> (b) General nature of industry, business, or establishment in which employed (or employer)		

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *July 15*, 191*4*  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *1914* to *1914*, that I last saw him *alive* on *1914*, and that death occurred, on the date stated above, at *11* m.

The CAUSE OF DEATH\* was as follows:  
*Chronic Endocarditis  
Valvular  
heart disease*

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Signature *Dr. J. B. Long* July 15, 1914 (Address) *Sedalia, Mo.*

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

BIRTHPLACE (City or town, State or foreign country) \_\_\_\_\_

PARENTS

NAME OF FATHER
BIRTHPLACE OF FATHER (City or town, State or foreign country)
MAIDEN NAME OF MOTHER
BIRTHPLACE OF MOTHER (City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) \_\_\_\_\_  
(ADDRESS) \_\_\_\_\_

Filed *Sept 7* 191*4* *J. B. Long* REGISTRAR

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL <i>Satisfactory Information Supplied.</i>	DATE OF BURIAL _____, 191 <i>4</i>
UNDERTAKER	ADDRESS

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[Approved by U. S. Census and American Public Health  
Association]

23583

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