

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

PLACE OF DEATH

County Ston

Township Washington

or Village _____

or City _____ (NO. _____)

Registration District No. 843

Primary Registration District No. 6106

File No. 37643

Registered No. _____

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

FULL NAME Joseph T. Allen

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Single
(Write the word)

DATE OF BIRTH Nov. 9, 1914
(Month) (Day) (Year)

AGE no yrs. no mos. 14 ds. IF LESS than 1 day, _____ hrs. or _____ min.?

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

BIRTHPLACE (City or town, State or foreign country) Ston Co. Mo.

PARENTS NAME OF FATHER Welford N. Allen BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo.
MAIDEN NAME OF MOTHER Lillie M. Taylor BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. N. Allen

(ADDRESS) Galena Mo

Filed 11/23 1914. L. Henson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Nov. 23, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Nov. 23, 1914, to Nov. 23, 1914, that I last saw him alive on Nov. 23, 1914, and that death occurred, on the date stated above, at 5 P. m. The CAUSE OF DEATH* was as follows:

119B 104 Gastritis
(Duration) ✓ yrs. ✓ mos. 1/2 ds.

Contributory (SECONDARY) ✓ (Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) L. Henson M. D. 11/23 1914 (Address) Galena Mo.

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ✓ yrs. ✓ mos. 14 ds. In the State ✓ yrs. ✓ mos. 14 ds.
Where was disease contracted if not at place of death? Place of death.
Former or usual residence ✓

PLACE OF BURIAL OR REMOVAL ✓ DATE OF BURIAL Nov. 23, 1914

UNDERTAKER None ADDRESS ✓

PHYSICIAN'S SIGNATURE AND OCCUPATION IN FULL. CAUSE OF DEATH IN PLAIN LANGUAGE. AGE AS PROPERLY CLASSIFIED.

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, Compositor, 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, peritonaeum*, 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.)

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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

PLACE OF DEATH

County Stone
 Township Washington
 or
 Village _____
 or
 City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 843 File No. _____
 Primary Registration District No. 6106 Registered No. _____

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

FULL NAME Joseph L alley

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX M COLOR OR RACE W SINGLE 1
 MARRIED _____
 WIDOWED _____
 OR DIVORCED _____
(Write the word)

DATE OF DEATH _____, 1914
 (Month) (Day) (Year)

DATE OF BIRTH _____, 1914
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, to _____, 1914, that I last saw h _____ alive on _____, 1914, and that death occurred, on the (date stated above), at _____ m.

AGE _____ yrs. _____ mos. _____ ds.
 IF LESS than 1 day, _____ hrs. _____ or _____ min.

The CAUSE OF DEATH* was as follows:

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

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) _____

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 (Signed) _____ M. D.
 _____ 1914 (Address) _____

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

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 _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____
 (ADDRESS) _____

PLACE OF BURIAL OR REMOVAL Galena Cemetery DATE OF BURIAL Nov. 23 1914

Filed 11/23 1914 J. L. Hanson REGISTRAR

UNDERTAKER None ADDRESS _____

N. B. V. - Attention should be carefully given to this information. If the informant should be stated EXACTLY OCCUPATION, it should state if important.

Satisfactory information supplied.

SUPPLEMENTARY

Satisfactory information supplied.

Revised United States Standard Certificate of Death

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

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