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.

THIS IS A PERMANENT RECORD

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

PLACE OF DEATH

County Newton

Township ~~Seneca~~ or Village or City Seneca (NO. ____ St.: ____ Ward)

Registration District No. 611 File No. 2617

Primary Registration District No. 4365 Registered No. 45

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

FULL NAME X Rosa Elizabeth Allen.

PERSONAL AND STATISTICAL PARTICULARS

SEX Female

COLOR OR RACE White

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widowed

DATE OF BIRTH X September 24, 1837 (Month) (Day) (Year)

AGE X 78 yrs. 3 mos. 2 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

BIRTHPLACE (City or town, State or foreign country) X Martinsburg, W. Va.

PARENTS
NAME OF FATHER X Bernard Doll
BIRTHPLACE OF FATHER (City or town, State or foreign country) X Martinsburg, W. Va.
MAIDEN NAME OF MOTHER X Elizabeth Showers.
BIRTHPLACE OF MOTHER (City or town, State or foreign country) X Martinsburg, W. Va.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) X Clara D. Allen.

(ADDRESS) X Wyandotte, Okla.

Filed Jan. 10, 1916. W. M. Campbell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 26, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 27, 1915, to Dec 26, 1915, that I last saw her alive on Dec 26, 1915, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
11A
10A 91

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) La Grippe

(Duration) ____ yrs. ____ mos. 17 ds.

(Signed) T. B. Duncan M. D.

Dec 28, 1915 (Address) Seneca 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. ____ 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 Seneca F. Mo. X

DATE OF BURIAL Dec. 28, 1915

UNDERTAKER N. E. Mitchell

ADDRESS Seneca Mo.

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

PLACE OF DEATH

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City .....(NO.....,.....St.:.....Ward)

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

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

.....(Month) .....(Day), *1*.....(Year)

AGE .....yrs.....mos.....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)

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 .....,191.....,..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

.....(Month) .....(Day), *191*.....(Year)

I HEREBY CERTIFY, that I attended deceased from .....,191....., to.....,191.....,

that I last saw h.....alive on.....,191.....,

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

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

(Signed).....M. D.

.....,191..... (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.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL .....,191.....
UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK

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.