

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

1 PLACE OF DEATH

County St. Louis
Township Central
or
Village
or
City

Registration District No. 789 File No. 3383
Primary Registration District No. 60330 Registered No. 26
(NO. 6520 Plymouth St. Ward)

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

2 FULL NAME Benjamin Allen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED widowed
(Write the word)

6 DATE OF BIRTH June 30th 1850
(Month) (Day) (Year)

7 AGE 65 yrs 7 mos 0 ds. If LESS than 1 day.....hrs. or.....min.?

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

9 BIRTHPLACE (City or town, State or foreign country) Pennsylvania

10 NAME OF FATHER Nathaniel Allen

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

12 MAIDEN NAME OF MOTHER Hannah Docter

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Bell Shields
(Address) 6520 Plymouth av

15 Filed Jan 31, 1916 W. H. Harrel Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH January 30th 1916
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 27th 1916 to Jan 30th 1916, that I last saw him alive on Jan 30th 1916, and that death occurred, on the date stated above, at 2nd m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
108 AV
(Duration) 7 yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary) none
(Duration) 7 yrs. 3 mos. 3 ds.

Signed: J. J. Healy M. D.
Jan 30th 1916 (Address) 2039 Wash St.

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

18 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.....

19 PLACE OF BURIAL OR REMOVAL Bethania DATE OF BURIAL 2-1 1916

20 UNDERTAKER Arthur J. Donnelly ADDRESS 2039 Wash St.

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, 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.)

PLACE OF DEATH

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BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH
RECEIVE A FEE FOR CERTIFICATED
UNTIL THEY ARE COMPLETED AS
PRESCRIBED BY LAW.MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATHCounty St. Louis
Township Central
or
Village
or
CityRegistration District No. 789 File No. 2383
Primary Registration District No. 6033 B Registered No. 26
(No. 6520 Plymouth St.: _____ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]FULL NAME Benjamin Allen

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED Widowed
(Write the word)DATE OF DEATH January 30th, 1916
(Month) (Day) (Year)DATE OF BIRTH June 30, 1827
(Month) (Day) (Year)HEREBY CERTIFY, that I attended deceased from Jan 27th, 1916, to Jan 30th, 1916, that I last saw h. alive on Jan 30th, 1916, and that death occurred, on the date stated above, at 2 P. m.AGE about 89 yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.The CAUSE OF DEATH* was as follows:
Lobar PneumoniaOCCUPATION (a) Trade, profession, or particular kind of work Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer)92
(Duration) _____ yrs. _____ mos. _____ ds.
Contributory none
(Secondary) (Duration) _____ yrs. _____ mos. _____ ds.BIRTHPLACE (City or town, State or foreign country) PennsylvaniaNAME OF FATHER Nacharal AllenBIRTHPLACE OF FATHER (City or town, State or foreign country) GermanyMAIDEN NAME OF MOTHER Gannach DoctorBIRTHPLACE OF MOTHER (City or town, State or foreign country) Germany(Signed) J. M. H. [Signature] M. D.
Jan 30th, 1916 (Address) 6033 B Plymouth St.

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

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

(Informant) Bele Shields

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

(ADDRESS) 6520 Plymouth St.

Where was disease contracted If not at place of death?

Former or usual residence.

Filed Jan 31, 1916 W. E. Harral REGISTRARPLACE OF BURIAL OR REMOVAL Bethania DATE OF BURIAL 2-1, 1916UNDERTAKER Arthur J. Donnelly ADDRESS 2039 Wash St.

Original file, date _____ 19____ All information called for must be written on this Supplementary Certificate.

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Jan - 1916
Jei

O. J. S.
St Louis Mo
Jefferson City Mo
Jan 1916

Revised United States Standard Certificate of Death

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

3383

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