

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

Do not use this space.

2253

1. PLACE OF DEATH

County Lawrence
Township Lincoln
City (No. _____) _____

Registration District No. 469
Primary Registration District No. 5-230

File No. _____
Registered No. 4
St. _____ Ward _____

2. FULL NAME

Blana Louise Allen

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX P 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Verify the word) Child

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-19-22

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
6 6 12 0 0

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN) Quenton
(STATE OR COUNTRY) Wade Co.

10. NAME OF FATHER Clay Allen

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Wade Co.
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Alice Beitz

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Missouri
(STATE OR COUNTRY) _____

14. INFORMANT Clay Allen
(Address) _____

15. FILED 3-1 19 29 W. S. Boney REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 1 19 29

17. I HEREBY CERTIFY That I attended deceased from Dec 24, 1928, to Jan 1st, 1929 that I last saw her alive on Jan 1, 1929, and that death occurred, on the date stated above, at 7 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia

10 1/2 (duration) yrs. mos. 7 ds.

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? NO DATE OF _____
WAS THERE AN AUTOPSY? NO
WHAT TEST CONFIRMED DIAGNOSIS? Clin. symptoms

(Signed) L. J. Holmes, M. D.
, 19 (Address) Miller Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Raye Spring DATE OF BURIAL 1-3 1928

20. UNDERTAKER J. W. Morris & Leiman Miller Mo ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK—THIS IS A CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. PHYSICIANS SHOULD STATE EXACTLY. AGE SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE CAREFULLY SUPPLIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. PHYSICIANS SHOULD STATE EXACTLY. AGE SHOULD BE CAREFULLY SUPPLIED.

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Lawrence
Township Lincoln
City (No.):

Registration District No. 469
Primary Registration District No. 5703.0

File No. 2253
Registered No.
St. Ward

2. FULL NAME

Clara Louise Allen

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S.
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 5-19-22

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED 2-1-23 V. & Jones REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 1 19 29

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

bronchial pneumonia

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRIBUTED IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

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

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH INK---THIS IS A PER

ORD

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may properly classified. Exact statement o

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

SUPPLEMENTARY

S-2253