

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.

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

Do not use this space.

1. PLACE OF DEATH
 County Jackson Registration District No. 399
 Township Kaw Primary Registration District No. 1052
 City K.C.M.O. (No. 519 Tracey, Ave.)
 St. _____ Ward _____

2. FULL NAME Tom Allen
 (a) Residence, No. 519 Tracey St. _____ Ward _____
 (Usual place of abode)
 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. (If nonresident, give city or town and State)

29598
 File No. _____
 Registered No. 4601
 St. _____ Ward _____

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>Colored</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Single</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb. 1860</u>		
7. AGE YEARS <u>72</u>	MONTHS <u>10</u>	DAYS _____
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.		If LESS than 1 day, _____ hrs. or _____ min.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		11. Total time (years) spent in this occupation
10. Date deceased last worked at this occupation (month and year)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>M.O.</u>		
13. NAME <u>John Allen</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>M.O.</u>		
15. MAIDEN NAME <u>Unknown</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Unknown</u>		
17. INFORMANT <u>Allie Buford</u> (ADDRESS) <u>405 Lybka, Ave</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Blue Ridge Lawn</u> DATE <u>11/8/32</u>		
19. UNDERTAKER <u>West Appling & Jones</u> (ADDRESS) <u>1200 Olive St.</u>		
20. FILED <u>Dec 6 1932</u> <u>M. M. Cerame</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 3rd 1932

22. I HEREBY CERTIFY, That I attended deceased from Deputy Coroner, 19____, 19____
 I last saw him live on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
Carbon monoxide gas poisoning accidental
 Date of onset _____

Other contributory causes of importance:
1786

Name of operation _____ Date _____
 What test confirmed diagnosis Autopsy Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
 If so, specify _____
 (Signed) [Signature] M. D.
 (Address) St. Mary's Hospital K.C.M.O.

WHITE PAPER WITH UNFADING INK—THIS IS A PERMANENT RECORD

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