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

4124

PLACE OF DEATH

nty. Henry

nship Hivlson

ge.

Registration District No. 311 File No.

Primary Registration District No. 5433 Registered No.

(NO. St.: Ward)

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

FULL NAME Robert Max Alldredge.

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.

V. S. No. 2.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
7.	W	

TE OF BIRTH January 27, 1926
(Month) (Day) (Year)

yrs. mos. 6 ds. | If LESS than 1 day, hrs. or min.?

UPATION
rade, profession, or cular kind of work None

eneral nature of industry, ess, or establishment in n employed (or employer) None

HPLACE
or town, or foreign country) Higgins Twp.

NAME OF FATHER J. A. Alldredge

BIRTHPLACE OF FATHER (City or town, State or foreign country) Andrew Co Mo

MAIDEN NAME OF MOTHER Effie Summa

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Henry Co Mo

ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

rmant) J. A. Alldredge

(ADDRESS) Slonberry Mo R.D.

March 10, 1927. C. N. Williamson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Feb 2, 1927
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 27, 1927, to Jan 27, 1927, that I last saw him alive on Jan 27, 1927, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

159

(Duration) yrs. mos. ds.

Contributory None
(SECONDARY)

(Duration) yrs. mos. ds.

Signed C. N. Williamson M. D.

Feb 2, 1927 (Address) Hartley 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 Chapel Hill Cemetery

DATE OF BURIAL Feb 3 1927

UNDERTAKER Eaton & Phillips

ADDRESS Slonberry Mo

V. S. No. 2.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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 occurr hospital or inst give its NAME of street and num

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

• 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)

I HEREBY CERTIFY, that I attended deceased

....., 191...., to....., 19

that I last saw h..... alive on....., 19

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

The CAUSE OF DEATH* was as follows:

.....

.....

.....

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

Contributory.....
(SECONDARY)

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

(Signed).....

....., 191..... (Address).....

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

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENT RECENT RESIDENTS)

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

Where was disease contracted if not at place of death? .....

Former or usual residence.....

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