SEP 2 8 1927

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

Do not use this space.

24127

1. PLACE OF DEATH
County Grundy
Township Trenton
City Trenton (No. ..... St. ..... Ward)
Registration District No. 330 5459
Primary Registration District No. .....
File No. .....
Registered No. .....

2. FULL NAME Almyra Katherine Allison
(a) Residence. No. 504 E. 17th St., 3 Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Moses Allison
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feby 8-1845
7. AGE Years 82 Months 5 Days 26 If LESS than 1 day, ... hrs. or ..... min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work retired
(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) Ohio
PARENTS
10. NAME OF FATHER J. B. Rex
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Ohio
12. MAIDEN NAME OF MOTHER Sarah Fox
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Findley Ohio (STATE OR COUNTRY) Ohio
14. INFORMANT Mrs Rex Allison
(Address) Woodward Oklahoma
15. FILED Aug. 6 1927 E. A. Duffy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 4 1927
17. I HEREBY CERTIFY, That I attended deceased from 8-3, 1927, to 8-4, 1927 that I last saw her alive on 8-4, 1927 and that death occurred, on the date stated above, at 850 P.m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchial Pneumonia
10 A
1/2
1 B
(duration) ..... yrs. ..... mos. 2 ds.
CONTRIBUTORY (SECONDARY) Congestion Liver
(duration) ..... yrs. ..... mos. 7 ds.
18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) W. D. Winningham, M. D.
8/6, 1927 (Address) Trenton, 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 I OO F Cem Edinburg
DATE OF BURIAL Aug 6 1927
20. UNDERTAKER R H Hemley
ADDRESS Trenton Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Grundy — Registration District No. 330 — File No.
Township Trenton — Primary Registration District No. 3459 — Registered No.
City (No. , St. Ward)

2. FULL NAME Almyra Katherin Allison
(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

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
(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)

PARENTS
10. N
11. B
ate primary cause of con-
Please sign and return.
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED Oct 11, 1927 E. A. Duffy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 4 1927

17. I HEREBY CERTIFY, That I attended deceased from , 19 to , 19 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
Don't know
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Congestion liver
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) W. D. Winningham, M. D
10-11, 1927 (Address) Trenton 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 — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. ...ould be stated ...HYSICIANS should s... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statem... CUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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