

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

Do not use this space.

43285

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1003
 City, St. Louis, Mo. No. 1720 Macklin

File No.....
 Registered No. 12592
 St..... Ward.....

2. FULL NAME

Olex Allison
 (a) Residence, No. 1720 Macklin Ave. St., 13 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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male | W.C. | Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1884-10-24

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

41 | 1 | 26

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER Abe Allison

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

12. MAIDEN NAME OF MOTHER Francis Davis

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

14. INFORMANT Francis Allison
 (Address) 1113 1/2 Sarah St

15. FILED 5-5 24 1928 Max C. Stankley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 20 1928

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....., 10:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Pulmonary Tuberculosis
234

CONTRIBUTORY (SECONDARY)..... (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?..... yes

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)..... J. W. Ferner, M.D.

(Address)..... Dep. Coroner

*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 Washington Park DATE OF BURIAL Dec 26 1928

20. UNDERTAKER A. L. Beal ADDRESS 2726 Lucas

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.

