

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. 389
 Township KAW Primary Registration District No. 1008
 City KANSAS CITY (No. 2704-EAST-69TH)

File No. 1648
 Registered No. 378
 St. _____ Ward _____

2. FULL NAME WALTER THOMAS ALLISON

(a) Residence, No. 2704-EAST-69TH 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. 2 mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE **4. COLOR OR RACE** WHITE **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** (write the word) SINGLE
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) NOVEMBER-5-1930
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
 2 19
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. NONE
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ **11. Total time (years) spent in this occupation** _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) KANSAS CITY MISSOURI

13. NAME WALTER T. ALLISON

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ORRICK MISSOURI

15. MAIDEN NAME JOSEPHINE GEORGE

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) GREENVILLE MISSISSIPPI

17. INFORMANT (ADDRESS) MR. WALTER T. ALLISON 2704-EAST-69TH ST.

18. BURIAL, CREMATION, OR REMOVAL PLACE FOREST HILL DATE JANUARY-24-1933

19. UNDERTAKER (ADDRESS) D. W. NEWCOMER'S SONS KANSAS CITY, MISSOURI

20. FILED Jan 24 1933 M. M. Coover Registrar

MEDICAL CERTIFICATE OF DEATH

1. DATE OF DEATH (MONTH, DAY, AND YEAR) JANUARY-22-1933

2. I HEREBY CERTIFY That I attended deceased from Jan 21, 1933, to Jan 22, 1933
 Last saw him alive on Jan 22, 1933 Death is said to have occurred on the date stated above, at 11:00 P.

The principal cause of death and related causes of importance were as follows:
Pneumonia - 1-20-33
108
 Other contributory causes of importance: 108

8. Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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) G. C. Penley M. D.
 (Address) 206 Maple Bldg

206 Argyle Bldg.

11:30-5