

JUN 23 1937

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

Do not use this space.

1. PLACE OF DEATH

County Lewis
Township Waller
City Waller

Registration District No. 483

Primary Registration District No. 5-647

File No. 20559

Registered No. _____
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ 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)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 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 Single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 17-1857
7. AGE YEARS 85 MONTHS 18 DAYS 1 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as planer, sawyer, bookkeeper, etc. Housekeeper
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) 1 year 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Washington DC

13. NAME Mathew E. Allison

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Washington DC

15. MAIDEN NAME Deanna Miller

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Washington DC

17. INFORMANT (ADDRESS) A. E. Allison

18. BURIAL, CREMATION, OR REMOVAL PLACE Waller DATE 5-19 1937

19. UNDERTAKER (ADDRESS) W. S. Kelly

20. FILED May 18, 1937 ms D. B. Allen Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 18, 1937

22. I HEREBY CERTIFY, That I attended deceased from May 20, 1936, to May 18, 1937

I last saw him alive on May 17, 1937 Death is said to have occurred on the date stated above, at 3 P. M.

The principal cause of death and related causes of importance were as follows:

Calcemia of stomach Date of onset _____

Other contributory causes of importance:

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) W. C. E. Todd, M. D.

(Address) Waller

