

APR 13 1939

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

11789

Do not use this space.

1. PLACE OF DEATH

(a) County Demiseat Registration District No. 653
 (b) Township Broggsdais Primary Registration District No. 5871
 (c) City _____ or _____ (d) Street No. _____ St.
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

Miles C. Allison
 (a) Residence, No. _____ St. _____
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Millie Allison
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown
 AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.

7. OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as 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) Alabama

13. NAME Unknown
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

15. MAIDEN NAME Unknown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT C. H. Lee
 (ADDRESS) Broggsdais, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Broggsdais, Mo DATE 3/30/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) La Farge and Co
Cumttersville, Mo

20. FILED 3-30-39 Brooks
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 29, 1939
 22. I HEREBY CERTIFY, That I attended deceased from March 27, 1939, to March 29, 1939
 I last saw him alive on March 27, 1939. Death is said to have occurred on the date stated above, at 11:45 p.m.
 The principal cause of death and related causes of importance were as follows:

Bout's DiseaseDate of onset
6 p.m. approx.

Other contributory causes of importance:

3 or 4 hemorrhages from the esophageal or gastric vessels.

Name of operation _____ Date of _____
 What test confirmed diagnosis? L.P.S. Was there an autopsy? no

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? no
 If so, specify _____ (Signed) As Shrey, M. D.
 (Address) Hayti, Mo.

RECEIVED

District Health Officer No. 3

District File Number 39-27

Date Filed 4-11-3

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Not Embalmed, Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.