

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

850 AUG 12 1939

26951
Do not use this space.

1. PLACE OF DEATH

(a) County Saline.

Registration District No. 799

(b) Township

Primary Registration District No. 4479

Registered No. 32

(c) City Slater, Mo.

(d) Street No.

(If death occurred in Hospital or Institution, write its name instead of street and number)

(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 Elzia Aligy

(a) Residence, No.

(Usual place of abode, if no street address, write county or city)

St.

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

Colored

5. SINGLE, MARRIED, WIDOWED, OR

MARRIED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF
(OR) WIFE OF

Annie Aligy

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

November-9-1881

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1
day, ... hrs.
or min.

57

7

26

OCCUPATION

8. Trade, profession, or particular kind of
work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work
was done, as saw mill, bank, etc.

Laborer

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)

Steinmetz Mo.

FATHER

13. NAME

Jim Aligy

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

Don't Know

MOTHER

15. MAIDEN NAME

Dina Estill

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

Don't Know

17. INFORMANT
(ADDRESS)

Annie Aligy
Slater, Mo.

18. BURIAL, CREMATION, OR REMOVAL

PLACE Glasgow Mo

DATE July-8-39

19. FUNERAL DIRECTOR (NAME)
(ADDRESS)

Jones & Salzer
Slater, Mo.

20. FILED

July 6, 1939

W. M. T. Hall

Local Registrar

MEDICAL CERTIFICATE OF DEATH

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

7/5, 1939

22. I HEREBY CERTIFY, That I attended deceased from

6/30, 1939 to 7/5, 1939

I last saw him live on 7/5, 1939 Death is said

to have occurred on the date stated above, at 8:20 a.m.

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

Cerebral apoplexy Date of onset 6/30

Other contributory causes of importance:

Name of operation none

Date of —

What test confirmed diagnosis? symptoms 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)

(Address)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 8/19/31

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
Jones
working under my personal supervision.

Registered Apprentice No.

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.