

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 108

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County BUCHANAN
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME JENNIE ALLISON 425

3. (b) If veteran, name war _____ 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife H. D. Allison 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased JUNE 7th 1894
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>45</u>	<u>7</u>	<u>23</u>	hr. _____ min. _____

9. Birthplace: Buchanan County Mo. D
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business HOME

MOTHER FATHER { 12. Name JAMES R. O'AYLE
 { 13. Birthplace Buchanan County Mo.
 { 14. Maiden name MABIE WYLLIE
 { 15. Birthplace L. C. DEFE, Mo.

16. (a) Informant MR. H. D. Allison

(b) Address 1217 N. 7th St. Joseph, Mo

17. (a) BURIAL (b) Date thereof FEB. 1st 40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation ASHLAND CEMETERY

18. (a) Signature of funeral director FLEEMAN & SON, INC.

(b) Address 1946 CALHOUN, St. Joseph, Mo

19. (a) FEB 1-40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 1217 N. 7th.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 30th
year 1940 hour 8:30 minute A. M.

21. I hereby certify that I attended the deceased from Jan. 28, 1940
Jan. 28 1940, to Jan. 30 1940;
that I last saw her alive on Jan. 30 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Generalized peritonitis</u>	<u>4 days</u>
<u>Gangrene of all of small & large bowel</u>	<u>4 days</u>
<u>Due to mesenteric thrombosis & multiple thrombi</u>	<u>4 days</u>
<u>Due to Auricular fibrillation & mitral stenosis</u>	<u>2-3 yrs.</u>

Other conditions _____ (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: Same as above.
Of operations Same as above.
Of autopsy Same as above.
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place)
(a) Means of injury _____
23. Signature Cabray Wortley (M. D. or other) _____
Address St. Joseph, Mo Date signed 1-30-40

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 _____
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed

C. G. Swan

Licensed Embalmer No. _____

P. O. Address _____

St. Joseph

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.