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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 10 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38113

Registration District No. 73 Primary Registration District No. 3006 Registrar's No. 251

1. PLACE OF DEATH: 3
(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 311 N. Williams St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Months (Specify whether years, months or days)
In this community Entire Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Boone
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Columbia Township - Route 6
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME JULIA ALLTON
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Deceased
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased April (Month) 17 (Day) 1864 (Year)
8. AGE: Years 76 Months 7 Days 3 If less than one day ... hr. ... min.
9. Birthplace Boone County (City, town, or county) Mo (State or foreign country)
10. Usual occupation Retired Housekeeper
11. Industry or business At Home
FATHER 12. Name [illegible] Wade
13. Birthplace Boone County (City, town, or county) Mo (State or foreign country)
MOTHER 14. Maiden name [illegible]
15. Birthplace Boone County (City, town, or county) Mo (State or foreign country)
16. (a) Informant Mrs. Fred [illegible]
(b) Address Columbia Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22 '40 (Month) (Day) (Year)
(c) Place: burial or cremation Columbia Cem.
18. (a) Signature of funeral director Parker's
(b) Address Columbia, Mo
19. (a) 11/20/40 (Date received local registrar) (b) Allie Selby (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 20 year 1940 hour 9:00 minute A. M.
21. I hereby certify that I attended the deceased from July, 1940, to Nov 20, 1940; that I last saw her alive on Nov 14, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Myocarditis	2 yrs.
Chronic Cholecystitis Cholelithiasis	10 yrs.
Due to Generalized Arteriosclerosis	

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations [illegible]
Of autopsy

PHYSICIAN 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? (Specify type of place)
While at work? (e) Means of injury
23. Signature James M. Baker (M. D. or other) MD
Address Columbia, Mo. Date signed 11-20-40

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.

No. 2B
-2-21-40
1 X22659

MISSOURI STATE BOARD OF HEALTH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State File No. 38113

Registration District No. 73 Primary Registration District No. 3006 Registrar's No. 251

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

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Boone
(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home of Mrs. Allen Bryan
311 N Williams St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 months
In this community all life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Julia Allton
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)
8. AGE: Years 76 Months 7 Days 3 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 20
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.
Immediate cause of death Chr. Myo Carditis
Chr. Cholecystitis with
Cholelithiasis
Duration
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN — 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?
(Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed