

No. 2
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FILED APR 21 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

9304

State File No.

2714

Registration District No. 791

Primary Registration District No. 1003

Registrar's No.

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town. St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 Days
(Specify whether
In this community 12 yrs.
years, months or days)

3. (a) PRINT FULL NAME John Allison

3. (b) If veteran, name war. Unknown 3. (c) Social Security No. Unknown

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced. Married

6. (b) Name of husband or wife Edith Allison 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased. September 26, 1876
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>64</u>	<u>5</u>	<u>1</u>	hr. min.

9. Birthplace. Portland, Oregon
(City, town, or county) (State or foreign country)

10. Usual occupation Barber

11. Industry or business Barber Shop

MOTHER FATHER { 12. Name William Allison

13. Birthplace California
(City, town, or county) (State or foreign country)

14. Maiden name Margaret O'Brien

15. Birthplace Kansas
(City, town, or county) (State or foreign country)

16. (a) Informant Ann Morrison

(b) Address St. Louis City Hospital #1

17. (a) Cremation (b) Date thereof 3-27-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Crematory

18. (a) Signature of funeral director W. J. White

(b) Address City Hospital No. 1

19. (a) MAR 26 1941 (b) J. W. Bredek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 11
(c) City or town St. Louis 000
(If outside city or town limits, write "RURAL") 17
(d) Street No. 2800a North Sarah St. 9
(If rural, give location)
(e) If foreign born, how long in U. S. A.? X 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 27,
year 1941 hour 5:45 minute A.M.

21. I hereby certify that I attended the deceased from February
19, 19 41 to February 27, 19 41;
that I last saw him alive on February 27, 19 41;
and that death occurred on the date and hour stated above.

Immediate cause of death Infarct of heart.

Due to Coronary thrombosis

Due to MI

Other conditions MI
(Include pregnancy within 3 months of death)
Major findings: Infarct of heart.
Of operations Pericarditis acute
Of autopsy Splenomegaly, Arteriosclerosis

Duration
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 0

23. Signature David Friedman MD (M. D. or other)
Address 1515 Lafayette Avenue Date signed 3/3/41

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 with the above constitutes grounds for revocation of license.)

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