No. 2
-1-4-41
5-17-39
I X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10038

Registration District No. FILED APR 3 1942

Primary Registration District No. 50

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Audrain Co.

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Audrain 004

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Jefferson Davis Allison

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased March (Month) 16 (Day) 1861 (Year)

8. AGE: Years 80 | Months 10 | Days 2 | If less than one day hr. min.

9. Birthplace Amherst Co, Virginia (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER

12. Name John Allison

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

14. Maiden name Nancy Belle

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

16. (a) Informant Mary L. Harrison

(b) Address 529 W. Love Mexico Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 20-42 (Month) (Day) (Year)

(c) Place: burial or cremation Mexico Mo.

18. (a) Signature of funeral director M. O'Phelan Bro.

(b) Address Mexico Mo.

19. (a) 1-20-42 (Date received local registrar) (b) Mrs. Archie Planter (Registrar's signature)

10 77

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 16

year 1942 hour 1/15 minute P.M.

21. I hereby certify that I attended the deceased from Oct. 1941 to Jan 18 1942, that I last saw him alive on Jan 18 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Gangrene of both Ext - arteo - Sclerosis (generalized)	2 Months
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 Mexico Mo. Date signed 1/19/42

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 Roy A. McPhee

Licensed Embalmer No. 1133

P. O. Address Milan, Mo

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.

V. S. No. 2B
0M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.....

Registration District No..... Primary Registration District No..... Registrar's No.....

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

1. PLACE OF DEATH:

(a) County Audrain

(b) City or town Rural, Wilson
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether years, months or days)

In this community.....

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) Citizen of foreign country?.....(Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME Jefferson D. Allison

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife.....

6. (c) Age of husband or wife if alive.....years

7. Birth date of deceased Mar (Month) 10 (Day) 1868 (Year)

8. AGE: Years 80 | Months 10 | Days 22 | 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) 1-20-42 (Date received local registrar) (b) Mrs. Arch Playter (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day..... year 1942 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.

	Duration
Immediate cause of death.....	
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.....

SUPPLEMENTARY

10038