DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 2 1942

Registration District No. 85

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1001

State File No. 10189

Registrar's No.

X28390

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: Mo Meth Hosp (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 4 days (Specify whether years, months or days)

In this community: ~~life~~ 4 days

2. USUAL RESIDENCE OF DEASCED:

(a) State: Missouri (b) County: Buchanan

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

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

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

If yes, name country

3. (a) PRINT FULL NAME: Rachel Allison

3. (b) If veteran, name war: No

3. (c) Social Security No. No

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: William Allison

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

7. Birth date of deceased: June (Month) 13 (Day) 1858 (Year)

8. AGE: Years 83 Months 8 Days 25 If less than one day hr. min.

9. Birthplace: (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Alexander Campbell

13. Birthplace: North Carolina (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name: Caroline White

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

16. (a) Informant: Mrs Bud Allison

(b) Address: Faucett Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Mar 10 1942 (Month) (Day) (Year)

(c) Place: burial or cremation: Yates Cemetery at Faucett

18. (a) Signature of funeral director: Fleman Funeral Home

(b) Address: St Joseph Missouri

19. (a) 3-10-42 (Date received local registrar) (b) H. J. Mattlebush (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8 year 1942 hour 7 minute 50 A.M.

21. I hereby certify that I attended the deceased from March 6 1942 to March 8 1942 that I last saw her alive on March 8 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: pneumonia — Duration: 1 week

Due to: infirmities of old age.

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: John R Fogarty (M. D. or other) M.D.

Address: 131 Faucett Date signed 3-10-42

(Licensed Embalmer's Statement on Reverse Side)

Paul Forgrave

APR 28 1942

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 .....

Mar 8 1942 ....., Registered Apprentice No. .....

working under my personal supervision.

Signed: John A. Hurley

Licensed Embalmer No. 4080

P. O. Address St Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi 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

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STANDARD CERTIFICATE OF DEATH

State File No. 10189

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: 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: Mo. Methodist Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 4 days (Specify whether years, months or days)

In this community: 4 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Buchanan

(c) City or town: Faucett
(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: Rachel Allison

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: W

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

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

7. Birth date of deceased: June (Month) 13 (Day) 1853 (Year)

8. AGE: Years: 89 Months: 8 Days: ..... If less than one day: ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER

12. Name .....

13. Birthplace: ..... (City, town, or county) N. Carolina (State or foreign country)

14. Maiden name .....

15. Birthplace: ..... (City, town, or county) Mo (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: May Day: 8 Year: 1942 hour ..... minute ..... M.

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

Immediate cause of death: Pneumonia, bronchial — Duration: Few

Due to: Infirmities of old age

Due to .....

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

Major findings: Of operations: 107

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? .....

While at work? ..... (Specify type of place) (e) Means of injury .....

23. Signature: Paul Tompkins (M. D. ~~or other~~)

Address ..... Date signed .....

SUPPLEMENTARY