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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 29 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **11225**

1. PLACE OF DEATH:
(a) County **ST. LOUIS**
(b) City or town **ST. LOUIS**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
LITTLE SISTERS OF POOR-3225 N. FLORISSANT
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 YEARS**
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT WILLIAM ALLISON
FULL NAME
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 **OCT. 18, 1860**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
83 1 22 hr. _____ min.

9. Birthplace **DEPHOS OHIO**
(City, town, or county) (State or foreign country)

10. Usual occupation **RETIRED LABORER**

11. Industry or business _____

MOTHER FATHER { 12. Name **GEORGE ALLISON**
13. Birthplace **DONT KNOW OHIO**
(City, town, or county) (State or foreign country)
14. Maiden name **MARY MILLS**
15. Birthplace **DONT KNOW OHIO**
(City, town, or county) (State or foreign country)

16. (a) Informant **SISTER JAENNE**

(b) Address **3225 N. FLORISSANT AVE.**

17. (a) **BURIAL** (b) Date thereof **12-18-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **CALVARY CEMETERY**

18. (a) Signature of funeral director **Arthur Donnelly**

(b) Address **3840 Lyndell Blvd**

19. (a) **DEC 17 1943** (b) **J. F. Bruck**
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO.** (b) County **000 17**
(c) City or town **ST. LOUIS** **9 20**
(If outside city or town limits, write "RURAL")
(d) Street No. **3225 N. FLORISSANT AVE.**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DEC.** day **10**
year **1943** hour **11** minute **7** M.

21. I hereby certify that I attended the deceased from **Dec 1** 19**43** to **Dec 10** 19**43**
that I last saw him alive on **Dec 10**, 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis**

Due to _____

Due to _____

Other conditions **Acute upper respiratory infection**
(Include pregnancy within 3 months preceding death) **de Giffie**

Major findings: Of operations **None**

Of autopsy **None**

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 **Bernard H. Stoltz** (M. D. or other)

Address **2301 Salisbury St** Date signed **12-12-43**

Duration **???**
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 Stanley Marshall
Licensed Embalmer No. 2868
P.O. Address 3840 Rindsee

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.