

FILED JAN 10 1943

Primary Registration District No. 4503

Registrar's No. 49

1. PLACE OF DEATH: Stoddard
 (a) County Stoddard
 (b) City or town Bernie
 (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 _____)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Stoddard
 (c) City or town Bernie 193
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location) 0
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME J.W. Allison

3. (b) If veteran, name war Spanish Amer. 3. (c) Social Security No. no

4. Sex Male 5. Color or race W. 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Viola Allison 6. (c) Age of husband or wife if alive 53 years
 7. Birth date of deceased Feb 4 1878
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 10 20 hr. ✓ min.

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

10. Usual occupation grocery clerk

11. Industry or business _____

12. Name unknown

13. Birthplace _____ (City, town, or county) (State or foreign country) 9

14. Maiden name unknown

15. Birthplace _____ (City, town, or county) (State or foreign country) 9

16. (a) Informant Viola Allison wife

(b) Address Bernie Mo

17. (a) Burial (b) Date thereof Dec 28 1943
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bernie Mo

18. (a) Signature of funeral director Funeral Home

(b) Address Campbell Mo

19. (a) 12-27-43 (b) Corcie Miller
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24
 year 1943 hour 12:25 minute 12:25 P.M.

21. I hereby certify that I attended the deceased from 12-18 to 12-24, 1943
 that I last saw him alive on 12-23, 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchial asthma + influenza
 Due to _____

Due to _____
 Other conditions: _____ (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations: _____

Of autopsy: _____

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?

23. Signature Dawson Ryan (M. D. or other) MD
 Address Bernie Mo Date signed 12-24-43

Duration

1 Week

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

103
0

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 144-54

Date Filed 1-7-44

JAN 18 1944

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 Christina Lundeen

Licensed Embalmer No. 4227

P. O. Address Campbell

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.