

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Waynes mo. Rte. 12
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: neely hosp
(If not in hospital or institution, write street number or location) _____
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo. (b) County Butler
(c) City or town Waynes mo. Rte. 12
(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 Heraman Dwight Alliston

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 U
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 29 1940
(Month) (Day) (Year)

8. AGE: Years 3 Months 8 Days 8 If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name James Roy Alliston
13. Birthplace Rock Co. Illinois (City, town, or county) (State or foreign country)
14. Maiden name Chesa Rush
15. Birthplace Arkansas (City, town, or county) (State or foreign country)

16. (a) Informant J. R. Alliston

(b) Address Waynes, mo. Rte. 12

17. (a) Burial (b) Date thereof 9-9-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hinney

18. (a) Signature of funeral director W. W. Dohy

(b) Address Carving Park

19. (a) 7-10-44 (b) Belle Kinne
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 7
year 1944 hour _____ minute 4:10 A.M.

21. I hereby certify that I attended the deceased from June 23 1944 to July 7 1944
that I last saw her alive on July 5 1944
and that death occurred on the date and hour stated above.

Immediate cause of death lyphoid fever

Due to _____
Due to _____

Other conditions whispering cough
(Includes pregnancy within 3 months of death)
pruritic - later -

Major findings: _____
Of operations _____
Of autopsy _____

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? _____

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

23. Signature Heraman Alliston (M. D. or other) _____
Address Waynes mo. Rte. 12 Date signed 7/7/44

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

200

RECEIVED

District Health Office No. 2,

District File Number 744-978

Date Filed 7-20-44

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.