

FILED OCT 20 1944

Registration District No. 518

Primary Registration District No. 1003

State File No. _____

Registrar's No. 8688

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

1. PLACE OF DEATH:

(a) County.....
 (b) City or town ST. Louis, MO.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Isolation Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 9/19/44 to 10-9-44
 In this community 0 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Howell 46
 (c) City or town ST. Louis, MO.
 (If outside city or town limits, write "RURAL")
 (d) Street No. West Flains, MO
 (If rural, give location) N.R.
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Dewitt Allison

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Colored 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased June 22 1910
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>34</u>	<u>3</u>	<u>18</u>	hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business Charlie Allison

12. Name Charlie Allison

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

14. Maiden name Mary ? (State or foreign country)

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

16. (a) Informant Viola Beckett

(b) Address 5600 Arsenal

17. (a) Interment (b) Date thereof 10-13-44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Crematory

18. (a) Signature of funeral director Gas Ryan

(b) Address 5000 Arsenal

19. (a) OCT 13 1944 (Date received local registrar) J. F. Bredeek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct., day 10 year 1944 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from 9/19/44 to 10/9/44
 that I last saw him live on Oct 9 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis
 Duration _____

Due to _____
 Due to _____

Other conditions Tbc. of spine
 (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 Dr. Maxwell (M. D. or other) _____
 Address 5600 Arsenal Date signed 10-11-44

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Not embalmed

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.