7. S. No. 2
0M—8-43
ev. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 17 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 14258

Registration District No. 233 Primary Registration District No. 5-95-2 Registrar's No. 20

1. PLACE OF DEATH:
(a) County Pike
(b) City or town Rural - Spencer Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 5 mi Northwest of Curryville
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no.
In this community 65 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Pike
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Spencer Township
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John Thomas Allison
3. (b) If veteran, name war No
3. (c) Social Security No.

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Carrie Allison
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June (Month) 9 (Day) 1864 (Year)

8. AGE: Years 80 Months 9 Days 9 If less than one day hr. min.

9. Birthplace Lincoln Co (City, town, or county) Mo (State or foreign country)
10. Usual occupation Farming
11. Industry or business

FATHER
12. Name Richard Allison
13. Birthplace D. K. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Harriet Shepherd
15. Birthplace D. K. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Carrie Allison
(b) Address Curryville (Rural)
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 21 - 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Mount Ave Cemetery
18. (a) Signature of funeral director W. B. Ellmore
(b) Address Bowling Green Mo
19. (a) March 20-45 (Date received local registrar) (b) Mrs Frank Gordon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 18 year 1945 hour 9 30 minute P M.
21. I hereby certify that I attended the deceased from 3/15/45, 19..., to 3/18/45, 19...; that I last saw him alive on 3/15/45, 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Pneumonia	1 Days
Due to: Arterio Sclerosis	yrs
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: G H M	

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 W. M. Owens (M. D. or other) 220
Address Bowling Green Mo Date signed 3/20/45

1149

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 4-45-61
Date Filed APR-1-3-1945

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 W. B. Elmore

Licensed Embalmer No. 3466

P. O. Address Bowling Green Mo.

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.