

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 21501

FILED JUN 10 1945  
Registration District No. 326

Primary Registration District No. 8494

Registrar's No.

1. PLACE OF DEATH

(a) County Sherman  
(b) City or town Verona, Mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: None  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 66 years (Specify whether years, months or days)  
In this community

3. (a) PRINT FULL NAME

William W. Allman  
3. (b) If veteran, name war No  
3. (c) Social Security No. No

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

(b) Name of husband or wife Mathie Allman  
6. (c) Age of husband or wife if alive 34 years

7. Birth date of deceased April 24-1879  
(Month) (Day) (Year)

8. AGE: Years 66 Months 12 Days 17 If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business

12. Name Thomas Allman

13. Birthplace New Liberty, Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Mathie Lott

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

16. (a) Informant William W. Allman

(b) Address Verona, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/12-45  
(Month) (Day) (Year)

(c) Place of burial or cremation Verona, Mo

18. (a) Signature of funeral director Frank Hyde

(b) Address Verona, Mo

19. (a) 5-12-45 (Date received local registrar) (b) Frank Hyde M.D. (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Sherman  
(c) City or town Verona, Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11th year 1945 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from 5/10/45 to 5/11/45  
that I last saw him alive on 5/11/45 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia  
Suppuration  
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?

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

23. Signature W. E. Eddy (M. D. or other)

Address Verona, Mo Date signed 5/12/45

Duration

5 days

10 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 5,

District File Number

Date Filed

643297  
6.16.45.

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

John F. McLean  
2516  
W. V. McLean 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.