DR HARRILL

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 15 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41585

Registration District No. 170 — Primary Registration District No. 2033 — Registrar's No.

1. PLACE OF DEATH:

(a) County LACLEDE

(b) City or town LEBANON
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
103 PEARL 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether
In this community ALWAYS years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LACLEDE 53

(c) City or town LEBANON 1
(If outside city or town limits, write "RURAL")

(d) Street No. 103 PEARL 2
(If rural, give location)

(e) Citizen of foreign country? NO 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME ROBERT ALLISON

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

4. Sex M 1 | 5. Color or race W | 6. (a) Single, widowed, married, divorced WIDOWER

6. (b) Name of husband or wife ALICE KNIGHT | 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased JULY (Month) 15 (Day) 1865 (Year)

8. AGE: Years	Months	Days	If less than one day
80	5	14	____ hr. ____ min.

9. Birthplace ____ (City, town, or county) TENN 1 (State or foreign country)

10. Usual occupation RETIRED FARMER

11. Industry or business

MOTHER / FATHER

12. Name WM ALLISON

13. Birthplace ____ (City, town, or county) TENN 1 (State or foreign country)

14. Maiden name NOT KNOWN

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

16. (a) Informant Cloe McCormick

(b) Address LEBANON MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-31-45 (Month) (Day) (Year)

(c) Place: burial or cremation HOUCK CEM

18. (a) Signature of funeral director PALMER'S

(b) Address LEBANON MO

19. (a) 1-8-46 (Date received local registrar) (b) Ora Frankenberger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 29
year 1945 hour 7 minute 30 P.M.

21. I hereby certify that I attended the deceased from 9-18- 1945, to 12-29 1945;
that I last saw ~~him~~ alive on 12-29- 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Myocarditis and Myocardial degeneration	(9)
Due to	
Due to	
Other conditions (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 R. E. Harrell (M. D. or other) MD

Address Lebanon, Mo Date signed 1-4-46

1455 (Licensed Embalmer's Statement on Reverse Side)

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

Received .....

Laclede County Health Unit

File No. 12-45-191

Date Filed 1/14/46

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 R A Palmer

Licensed Embalmer No. 1161

P. O. Address Lebanon Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.