

FILED FEB 14 1946 STANDARD CERTIFICATE OF DEATH

State File No. 2418

Registration District No. 60

Primary Registration District No. 4106

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Cedar  
(b) City or town Jerico Spgs. Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution X /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 yrs (Specify whether years, months or days)  
In this community 2 yrs

3. (a) PRINT FULL NAME Allie Jane Alexander

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Fredrick Alexander 6. (c) Age of husband or wife if alive 62 years  
7. Birth date of deceased May 16 1885  
(Month) (Day) (Year)

8. AGE: Years 60 Months 8 Days 10 If less than one day hr. min.

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

10. Usual occupation housewife home

11. Industry or business

12. Name Rube Holman

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

14. Maiden name Nan Holder

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

16. (a) Informant Alexander: Mr. Fredrick

(b) Address Jerico Springs, Mo.

17. (a) Burial (b) Date thereof 1-26-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Edna Anna Cemetery

18. (a) Signature of funeral director Gibson Funeral Home

(b) Address 1201 Bdwy Lamar, Missouri

19. Jan 26, 1946 (Date received local registrar) Maiden M. Ellis (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cedar 20  
(c) City or town Jerico Springs 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. X 0  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 25  
year 1946 hour 2:35 PM minute 0 M.

21. I hereby certify that I attended the deceased from 1-8-46 to 1-25-46  
that I last saw him or alive on 1-25-46  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration

Due to nephritis & myelodysplasia

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Of autopsy ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) (c) Means of injury

23. Signature J. Bannister (M. D. or other) Jan 26 1946  
Address Jerico Spgs. Mo. Date signed

RECEIVED

Officer No. 7,

1-46-128

2-13-46

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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

*Wm. B. Libson*

Licensed Embalmer No. 4137

P. O. Address Lawrence, Missouri

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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. 60

Primary Registration District No. 4106

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Cedar  
(b) City or town Jericó Springs  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(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

3. (a) PRINT FULL NAME

Allie J. Alexander

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE:

Years

Months

Days

If less than one day

60

8

16

hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county)

(State or foreign country) MO

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county)

(State or foreign country)

14. Maiden name \_\_\_\_\_

(City, town, or county)

(State or foreign country)

15. Birthplace \_\_\_\_\_ (City, town, or county)

(City, town, or county)

(State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (Burial, cremation, or removal)

(b) Date thereof \_\_\_\_\_

(Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (Date received local registrar)

(b) \_\_\_\_\_

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 21 Year 1946 Hour \_\_\_\_\_ minute \_\_\_\_\_ M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ above on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to Chronic nephritis

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 9232 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

2418