

S. No. 2  
M-5-43  
5-17-39  
I. X3667

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED JAN 14 1947**  
Registration District No. 192

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 41272  
Registrar's No. 23

Primary Registration District No. 4305

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

40085

1. PLACE OF DEATH:  
(a) County MCDona'd  
(b) City or town Anderson  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Anderson MO.  
(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

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County MCDona'd 60  
(c) City or town Anderson MO  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William McQueen Allison  
(b) If veteran, name war \_\_\_\_\_  
(c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color White 6. (a) Single, widowed, married, divorced Married  
7. Birth date of deceased Feb. 28 1864  
(Month) (Day) (Year)  
8. (b) Name of husband or wife Maggie Allison 6. (c) Age of husband or wife if alive 76 years

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>7</u>	<u>6</u>	hr. min.

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

10. Usual occupation Farming

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

12. Name Samuel Allison  
13. Birthplace TENN.  
(City, town, or county) (State or foreign country)

14. Maiden name Martha Field  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Maggie Allison  
(b) Address Anderson MO.

17. (a) Burial (b) Date thereof 10-9th, 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Anderson MO.

18. (a) Signature of funeral director Chas. W. Williams  
(b) Address Goodman MO

19. (a) 1-10-47 (b) Virginia Buck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month OCT. day 6  
year 1946 hour 12 minute 15 P. M.  
21. I hereby certify that I attended the deceased from Oct. 1st  
1946 to Oct. 6 19 46  
that I last saw him alive on Oct. 5 19 46  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Gastric Ulcer  
Duration 4 yrs

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy PTA

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? \_\_\_\_\_ Means of injury \_\_\_\_\_

23. Signature S. B. Bish (M. D. or other)  
Address Anderson, MO Date signed 10/10/46

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 6,

District File Number 147-106

Date Filed JAN 13 1947

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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.....

..... 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.**