

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 5 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12468

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 570

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. Methodist Hosp. O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 weeks
(Specify whether
In this community 44 years
years, months or days)

3. (a) PRINT
FULL NAME

Corinne Allison

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 single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 10, 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 1 10 hr. min.

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

10. Usual occupation public school teacher

11. Industry or business Humboldt School

12. Name David H. Allison

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

14. Maiden name Jerusha Logan

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

16. (a) Informant Miss Gertrude Selesman

(b) Address St. Joseph, Mo.

17. (a) burial (b) Date thereof 4/22/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Spruansat, Mo.

18. (a) Signature of funeral director Neaton Bowman

(b) Address St. Joseph, Mo.

19. (a) 4-29-47 (b) K. B. Jenkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 1923 Francis
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20th
year 1947 hour 5 minute 9 M. A.

21. I hereby certify that I attended the deceased from Febr 5, 1947, to April 20, 1947
that I last saw h. on alive on 4-20, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Unresolved Pneumonia Duration
Baron's of stomach
Subtotal Necrotomy
Resection of Transverse Colon } 2-15-47
Due to

Due to Influenza followed by } 3-10-47
pneumonia right middle
lobes which did
Other conditions not resolve - xray
(Include pregnancy within 3 months of death) evidence - repeated

Major findings:
Of operations B
Of autopsy H

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? _____

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

23. Signature L. Selesman (M. D. or other) MB
Address St. Joseph Mo Date signed 4-21-47

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

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

Paul Rapp

Licensed Embalmer No *23458*

P. O. Address *319 S. 10th St. Joseph, 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.