No. 300
10-47
5-17-39
I 3906

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 7 1948

Registration District No. 317

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28145

Primary Registration District No. 6076

Registrar's No. 1967

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 587 days (Specify whether years, months or days)

In this community 4½ years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1017 So. Compton
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME ALLISON, BAMA

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex Female

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Wesley Allison

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

7. Birth date of deceased August (Month) 7 (Day) 1918 (Year)

8. AGE: Years 30 | Months - | Days 9 | If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Arthur Howze

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

14. Maiden name Versie D. Perry

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

16. (a) Informant Hospital Records

(b) Address Robert Koch Hospital

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

(c) Place: burial or cremation BRENT ALA

18. (a) Signature of funeral director Floyd English

(b) Address 2931 Lucas Ave

19. (a) 8-20-48 (Date received local registrar) (b) Cecil A. Sharp M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month August day 16 year 1948 hour 6 minute 25 A.M.

21. I hereby certify that I attended the deceased from 1-7-47, 19__, to 8-16-48, 19__; that I last saw her alive on 8-16-48, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	28 mo. (???)
Due to: 13B	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: Thoracoplasty, Left	
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 Jerry N. Allen Jr (M. D. or other)

Address Robert Koch Hospital Date signed 8-16-48

(Licensed Embalmer's Statement on Reverse Side)

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 Burleson Englesh

Licensed Embalmer No. 7208

P. O. Address 293 Lucas Ave

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.