

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. 13367

FILED APR 23 1949

BIRTH NO. _____ REG. DIST. NO. 278 PRIMARY REG. DIST. NO. 3054 Registrar's No. 33

1. PLACE OF DEATH a. COUNTY <u>Pike</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>Pike</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Louisiana</u>)		c. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Louisiana</u>)	
c. LENGTH OF STAY (in this place) <u>10yrs</u>		d. STREET ADDRESS (If rural, give location) <u>223 North "B" St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>223 North "B" St.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>MAY</u> b. (Middle) <u>MINERVA</u> c. (Last) <u>ALLISON</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 3 1949</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5/25/1868</u>	9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>8</u>	IF UNDER 24 HRS. Hours <u></u> Mins. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>	11. BIRTHPLACE (State or foreign country) <u>Pike co; Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
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13a. FATHER'S NAME <u>James Dunlap Wimer</u>	13b. MOTHER'S MAIDEN NAME <u>Hanna Jane Oakie</u>	14. NAME OF HUSBAND OR WIFE <u>Clement Allison</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Clement Allison</u>	ADDRESS <u>Louisiana Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial Pneumonia</u>		<u>1 week</u>
	ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c) <u>Aneurysm of the abdominal Aorta</u>		<u>yrs.</u> <u>yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		<u>Carcinoma of the face with metastasis</u>	<u>3 yrs</u>

19a. DATE OF OPERATION -----	19b. MAJOR FINDINGS OF OPERATION -----	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) -----	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -----	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) ----- <u>022X</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) -----	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? -----
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22. I hereby certify that I attended the deceased from 6/17/48 **to** 4/3/49, **19**, **that I last saw the deceased alive on** 4/3/49, **19**, **and that death occurred at** _____ **m., from the causes and on the date stated above.**

23a. SIGNATURE (Degree or title) <u>Chas. H. Lewellen M.D.</u>	23b. ADDRESS <u>Louisiana, Missouri</u>	23c. DATE SIGNED <u>4/4/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>4/5/1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Riverview</u>	24d. LOCATION (City, town, or county) (State) <u>Louisiana Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Apr 14, 1949</u>	REGISTRAR'S SIGNATURE <u>Bernice Collier</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>GARNER & STEPHEN</u>	ADDRESS <u>LOUISIANA MO.</u>
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(Licensed Embalmer's Statement on Reverse Side)

No. 300
10-48

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2
1

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

AUG 23 1949
FEB 14 1950

APR 22 1949

RECEIVED
District Health Officer No. 10
District File Number 4-49-70
Date Filed APR 22 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Virginia M. Stearns

Signed _____
Student Embalmer

Licensed Embalmer No. 4645

P. O. Address Louisiana, 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.