

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **18885**

19 JUN 20 1949

BIRTH NO. _____ REG. DIST. NO. 59 PRIMARY REG. DIST. NO. 4099 Registrar's No. 86

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Pleasant Hill</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Pleasant Hill</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) <u>Silas</u> c. (Last) <u>Allred</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 10 1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>March 22, 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rock Island R.R.</u>	11. BIRTHPLACE (State or foreign country) <u>Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Bud Allred</u>	
13b. MOTHER'S MAIDEN NAME <u>Melinda Peek</u>		14. NAME OF HUSBAND OR WIFE <u>Ludora Allred</u>	
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>Ludora Allred</u>		ADDRESS <u>Pleasant Hill Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocarditis</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Bronchiectases</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES ☐ NO ☒		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) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT ☐ NOT WHILE ☐ WORK ☐ AT WORK ☐	
21f. HOW DID INJURY OCCUR? _____		22. I hereby certify that I attended the deceased from <u>5-11</u> , 19 <u>49</u> , to <u>6-10</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>6-10</u> , 19 <u>49</u> , and that death occurred at <u>7:40 A.m.</u> , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) <u>C. W. Williams MD</u>		23b. ADDRESS <u>Pleasant Hill Mo.</u>	
23c. DATE SIGNED <u>6-11-49</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>6-12-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Horseshoe Cem.</u>	
24d. LOCATION (City, town, or county) (State) <u>South of Kingsville Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Herrick</u>	
DATE REC'D BY LOCAL REG. <u>June 12, 1949</u>		REGISTRAR'S SIGNATURE <u>Laura J. Jones</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

NOV 5 1949

DEC 18 1957

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.....

.....
working under my personal supervision.

Student
Student Embalmer

Student Embalmer No.

Signed.....

Licensed Embalmer No. 3599

P. O. Address Pleasant Hill

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.