

No. 300
10-30
3

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4492

State File No.

FILED MAR 8 1954

BIRTH NO. _____ REG. DIST. NO. 120 PRIMARY REG. DIST. NO. 5444 Registrar's No. 27

1. PLACE OF DEATH a. COUNTY <u>Gentry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Gentry</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Athens</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Athens</u> <u>2380</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location) <u>Albany R. F. D.</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Ava</u>	b. (Middle) <u>Wilson</u>	c. (Last) <u>Allender</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 28, 1954</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>4/16/1896</u>	9. AGE (In years last birthday) <u>57</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>12</u>	IF UNDER 24 HRS. Hours <u></u> Min. <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	11. BIRTHPLACE (State or foreign country) <u>Monroe Co. Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
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13a. FATHER'S NAME <u>J. O. Wilson</u>	13b. MOTHER'S MAIDEN NAME <u>Catherine Wilson</u>	14. NAME OF HUSBAND OR WIFE <u>Verl Allender</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>481-05-8434</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Verl Allender</u>	ADDRESS <u>Albany, Mo.</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage.</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Kidney Infection</u>		<u>1 yr</u> <u>1 yr</u>
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 <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.) <u>at</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>331 X</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 Mar 10, 1954, to Feb 28, 1954, that I last saw the deceased alive on Feb 27, 1954, and that death occurred at 9:25 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Charles N. Williams M.D.</u>	23b. ADDRESS <u>Gentry Mo</u>	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>3/2/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Forrest Lawn</u>	24d. LOCATION (City, town, or county) (State) <u>Oskaloosa Iowa</u>
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DATE REC'D BY LOCAL REG. <u>Mar 1-54</u>	REGISTRAR'S SIGNATURE <u>Maudie Williams</u>	5462	25. FUNERAL DIRECTOR'S SIGNATURE <u>Clifford Brooks</u>	ADDRESS <u>Albany Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Clifford Brooks

Licensed Embalmer No.

3329

P. O. Address

Albany 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.