

FILED FEB 14 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

1047

Registration District No. 383

Primary Registration District No. 5655

Registrar's No. 10

1. PLACE OF DEATH a. COUNTY Lawrence		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Adair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Mt. Vernon TOWN		c. CITY OR TOWN Kirkville	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. State Sanatorium		d. STREET ADDRESS 602 E. Harrison	
Length of stay in lb 382 days		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Russell Middle Allred Last Allred			4. DATE OF DEATH Month Feb. Day 3, Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 18, 1894	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad maintenance		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles L. Allred			14. MOTHER'S MAIDEN NAME Nellie Spry		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 494-20-5224	17. INFORMANT Address San. records, Mo. State San., Mt. Vernon, Mo.		

18. CAUSE OF DEATH* [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of esophagus with metastasis to lungs, lymphnodes, liver, pancreas, both kidneys, & right wall of heart				INTERVAL BETWEEN ONSET AND DEATH ?	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) right wall of heart		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis 1 1/2 yrs. 150XA					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 6:15 Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1-17-56 to 2-3-57 and last saw him her alive on 2-3-57 Death occurred at 6:15 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) C. A. Brasler M.D.			22b. ADDRESS Mt. Vernon, Mo.		22c. DATE SIGNED 2-4-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2-4-57	23c. NAME OF CEMETERY OR CREMATORY Herman Springs		23d. LOCATION (City, town, or county) (State) Kirkville, Mo.
24. FUNERAL DIRECTOR Herman Schmeyer ADDRESS Springfield (Licensed Embalmer's Agent on Reverse Side)		25. DATE RECD. BY LOCAL REG. 2-4-57		26. REGISTRAR'S SIGNATURE Cecil Hendricks	

Health, Welfare, Public Service

300 1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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..

Student
Signature of Student Embalmer

Signed *H. J. Mc Cain*

Licensed Embalmer No. *27*

P. O. Address *Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.