

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002094
STATE FILE NUMBER

Health,
Welfare
Public
Service
14

300
1-57 4

REG FEB 13 1959 Registration District No. 209 Primary Registration District No. 304B Registrar's No. 32

1. PLACE OF DEATH a. COUNTY <u>MARION</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>RALLS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HANNIBAL</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>NEW LONDON</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>GRANT REST HOME</u>		Length of stay in 1b <u>17 MONTHS</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ELIZA</u> Middle <u>SUTTON</u> Last <u>ALLISON</u>	4. DATE OF DEATH Month <u>FEB.</u> Day <u>3</u> Year <u>1959</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 10 1852</u>	9. AGE (In years last birthday) <u>106</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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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 (City and state or country) <u>MADISONVILLE Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>SUTTON</u>	13b. MOTHER'S MAIDEN NAME <u>ANN SUTTON</u>	14. NAME OF HUSBAND OR WIFE <u>GEORGE ALLISON</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs Fannie Miller Frankford Mo.</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio sclerosis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4500</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____

20d. INJURY OCCURRED WHILE AT <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 _____
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21. I attended the deceased from Dec 24-1958 Feb-3-59 and last saw her/him alive on 12-24-58
Death occurred at 7 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Ch. Lucke</u> (Degree or title) <u>M.D.</u>	22b. ADDRESS <u>910 Broadway, Hannibal Mo</u>	22c. DATE SIGNED <u>Feb-4-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-6-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>New London Missouri</u>
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24. FUNERAL DIRECTOR <u>Sp. Meyers</u> ADDRESS <u>Frankford Mo. R. 2</u>	25. DATE RECD. BY LOCAL REG. <u>2-5-1959</u>	26. REGISTRAR'S SIGNATURE <u>Ch. M. Lucke, H. C. Fisher</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. All diseases in Part I must be causally related.

RECEIVED FEB 10 1959
MARION CO. HEALTH DEPT.
DATE FILED FEB 10 1959

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 Joe Fields Negron

Licensed Embalmer No. 4093
P. O. Address Trinidad, P.R.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.