

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-014003  
STATE FILE NUMBER

FILED MAY 15 1959

Registration District No. ~~180~~ 179 Primary Registration District No. 4292 Registrar's No. 51

300  
-57

1. PLACE OF DEATH a. COUNTY <b>Lincoln</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <b>Winfield</b> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Howard residence</b>		Length of stay in 1b <b>few hours</b>	d. STREET ADDRESS <b>4508 Shenandoah</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>MERRITT</b> Last <b>ALLOWAY</b>			4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1959</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 5, 1903</b>
9. AGE (In years last birthday) <b>55</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Production Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mid-Continent Sales</b>	11. BIRTHPLACE (City and state or country) <b>Elsberry, Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>Henry Clinton Alloway</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary Redd</b>		14. NAME OF HUSBAND OR WIFE <b>Mary Kathryn Alloway</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>yes-</b>	17. INFORMANT Address <b>Mrs. Mary K. Alloway - 4508 Shenandoah -St. L.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary Thrombosis</b>			<b>1 year</b>
DUE TO (c) <b>Athero-sclerosis</b>			<b>4201 unknown</b>
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.)	
20c. TIME OF INJURY Hour 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 <b>May 10, 1959</b> to <b>May 10, 1959</b> and last saw him alive on <b>May 10, 1959</b> Death occurred at <b>12:30 a.m. - (D.S.T.)</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Frank L. Sutton</b> (Degree or title) <b>D.O.</b>	22b. ADDRESS <b>Winfield, Mo.</b>	22c. DATE SIGNED <b>5/11/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>May 12, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City</b>	23d. LOCATION (City, town, or country) (State) <b>Elsberry, Missouri</b>
24. FUNERAL DIRECTOR <b>O. C. Ricks</b> ADDRESS <b>Elsberry, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>5-13-1959</b>	26. REGISTRAR'S SIGNATURE <b>Charlotte Leek</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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VS 1531 5 1259

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 *[Handwritten Signature]*

..... Licensed Embalmer No. *4012*

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