

**FEDERAL BUREAU OF INVESTIGATION
 DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS SEP 29 1959**

59-033510

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 8225**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dent		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN Salem		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Pershing Avenue.,		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Earl Middle H. Last Allison			4. DATE OF DEATH Month September Day 3 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/2/1908	9. AGE (last birthday) 51	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Seed Business	11. BIRTHPLACE (City and state or country) Lebanon, Missouri.		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Ellsworth Allison		13b. MOTHER'S MAIDEN NAME Jessie Appling		14. NAME OF HUSBAND OR WIFE Wilma Allison	
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. Unknown	17. INFORMANT Address Wilma Allison, Salem, Missouri.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction					INTERVAL BETWEEN ONSET AND DEATH 2 weeks
DUE TO (b) Coronary arteriosclerotic heart disease					?
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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 _____ a.m. _____ p.m. Month, Day, Year _____	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 8-19-59 to 9-3-59 and last saw her/him alive on 9-3-59 Death occurred at 5:20 pm on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE C. E. Mueller, M.D. (Degree or title)		22b. ADDRESS 634 N. Grand Blvd.		22c. DATE SIGNED 9/4/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9/6/1959	23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery		23d. LOCATION (City, town, or county) (State) Salem, Missouri.	
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd. ADDRESS		25. DATE RECD. BY LOCAL REG. SEP 5 1959		26. REGISTRAR'S SIGNATURE Noan Smith, M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 8 9 1959

Faint, mostly illegible text at the top of the page, possibly containing header information or a title.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *[Handwritten Signature]*

Licensed Embalmer No. 4193

P. O. Address *[Handwritten Address]*

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.