RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

EILED VS NOV 2 1960

-60-038891
STATE FILE NUMBER

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 95

DED

1. PLACE OF DEATH
a. COUNTY Lawrence
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mt. Vernon
Length of stay in 1b 19 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. State Sanatorium
Inside Limits Yes ☐ No ☒

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Butler
c. CITY OR TOWN Neelyville
Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location) Route 1
Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print) First: James Middle: Roy Last: Alliston
4. DATE OF DEATH Month: October Day: 25, Year: 1960
5. SEX Male
6. COLOR OR RACE White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 5-29-85
9. AGE (last birthday) 75
IF UNDER 1 YEAR Months Days; IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (City and state or country) Illinois
12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Not Known
13b. MOTHER'S MAIDEN NAME Not known
14. NAME OF HUSBAND OR WIFE Clara Alliston
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Address San. records, Mo. State San., Mt. Vernon, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary tuberculosis Far Advanced, Active — INTERVAL BETWEEN ONSET AND DEATH: approx. 1 yr.
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)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 10 - 6 - 60, to 10 - 25 - 60 and last saw ~~her~~ him alive on 10 - 25 - 60
Death occurred at 5:00 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C. Hellweg M.D.
22b. ADDRESS Mt. Vernon, Mo.
22c. DATE SIGNED 1025-60

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 10-25-60
23c. NAME OF CEMETERY OR CREMATORY City Cemetery
23d. LOCATION (City, town, or county) (State) Corning Arkansas

24. FUNERAL DIRECTOR Mac L. Fossett ADDRESS Mt. Vernon, Mo.
25. DATE REC'D BY LOCAL REG. 10-29-60
26. REGISTRAR'S SIGNATURE H. D. Fossett

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

NOV 2 1960

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_____ Signed Max L Fossett

Signature of Student Embalmer

Licensed Embalmer No. 4252

P. O. Address Mt Vernon

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co 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.