

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-047522

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 174 Primary Registration District No. 3035 Registrar's No. 100

FILED DEC 18 1962

VS 300  
Rev. 4/59

6542

2540

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95411

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lexington</u>		Length of stay in 1b <u>15 yrs.</u>	c. CITY OR TOWN <u>Lexington</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Memorial</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>R. #1</u> (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>Everett</u> Last <u>Allison</u>		4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lubricator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lake City Arsenal</u>	9. AGE (last birthday) <u>59</u> IF UNDER 1 YEAR Months <u>10</u> Days <u>15</u> IF UNDER 24 HR Hours <u></u> Min. <u></u>
11. BIRTHPLACE (City and state or country) <u>Higginsville, Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Noah Allison</u>		13b. MOTHER'S MAIDEN NAME <u>Fannie Sharp</u>	
14. NAME OF HUSBAND OR WIFE <u>none</u>		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. <u>486-26-7530</u>		17. INFORMANT <u>Charles H. Allison</u> Address <u>Excelsior Springs</u>	
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>Congestive heart failure</u> DUE TO (b) <u>due to duodenal ulcer (ruptured about 6:00 PM)</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Nephrosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>
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 - <u></u> Month, Day, Year a.m. <u></u> p.m. <u></u>	
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 <u>12-14-61</u> to <u>12-6-62</u> and last saw her alive on <u>Dec. 6, 1962</u> Death occurred at <u>11:00 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Dr W Ward MD</u> (Degree or title)		22b. ADDRESS <u>Lexington, Missouri</u>	
22c. DATE SIGNED <u>12, 8, 62</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>12-8-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>City</u>	
23d. LOCATION (City, town, or county) (State) <u>Higginsville, Missouri.</u>		24. FUNERAL DIRECTOR <u>Forrest A. Hoefer</u> ADDRESS <u>Higginsville, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>12-8-62</u>		26. REGISTRAR'S SIGNATURE <u>Wm E. F. [Signature]</u>	

(Licensed Embelmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

DEC 20 1962

### 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 Forrest R. Hoefler

Licensed Embalmer No. 4801

P. O. Address Higginsville, 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.