

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24439

FILED JUL 28 1949

BIRTH NO. _____		REG. DIST. NO. 297		PRIMARY REG. DIST. NO. 6022		Registrar's No. 61	
1. PLACE OF DEATH a. COUNTY <u>Ray</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Ray</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rayville, Mo.</u>		c. LENGTH OF STAY (in this place) <u>41 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rayville, Mo.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>- /</u>				d. STREET ADDRESS (If rural, give location) <u>-</u>			
3. NAME OF DECEASED (Type or Print) <u>George Albert Allison</u>			a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH <u>July 19, 49</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>Married</u>		8. DATE OF BIRTH <u>July 15, 1863</u>	
9. AGE (In years last birthday) <u>86</u>		10. MONTHS <u>0</u>		11. DAYS <u>4</u>		12. HOURS & MIN. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drug Store</u>		11. BIRTHPLACE (State or foreign country) <u>Orrick, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Christopher Allison</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Williams</u>		14. NAME OF HUSBAND OR WIFE <u>Minnie Allison</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>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Minnie Allison, Rayville, Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>Senile Arteriosclerotic Hypertension</u>  DUE TO (c) <u>Auricular Fibrillation</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 1/2</u> <u>3 1/2 X</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Rayville Ray Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>July 1, 1949</u> , to <u>July 19, 1949</u> , that I last saw the deceased alive on <u>July 18, 1949</u> , and that death occurred at <u>5 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Oletus E. Buehrer MD</u>				23b. ADDRESS <u>Lansum Mo.</u>		23c. DATE SIGNED <u>July 21, 1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>July 21, 49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>New Hope Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Ray County, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>July 23, 1949</u>		REGISTRAR'S SIGNATURE <u>Malcolm Jackson</u>		273		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Quest-Life F. Home, Richmond, Mo.</u>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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RECEIVED JUL 2<sup>nd</sup>  
District Health Officer No. 8.

District File Number .....

Date Filed 7-29-49

**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.

Signed Lawrence J. West .....

Signed.....  
Student Embalmer

Licensed Embalmer No. H. D. 96

P. O. Address Richmond, 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 this body is not embalmed, fact should be so stated above.