

467
MAR 16 1928

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

4151

1. PLACE OF DEATH

County Buchanan

Registration District No. 85

Township St Joseph

Primary Registration District No. 1001

City St Joseph

(No. State Hospital #2.)

File No. 168

Registered No. 168

St. Ward

2. FULL NAME

John C Allison

(John C. Allison)

(a) Residence. No. St. Ward. Liberty, Mo.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

3. SEX

M

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Mary E Gross

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

2/4/1854

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

73

3

5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Schoolteacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(retired)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

710

PARENTS

10. NAME OF FATHER

Christopher Allison

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

710

12. MAIDEN NAME OF MOTHER

Mary E Williams

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

710

14. INFORMANT

(Address)

State Hospital, St. Joseph, Mo.

15. FILED

REGISTRAR

John G. Allison

16. DATE OF DEATH (MONTH, DAY AND YEAR)

2/9/1928 19

17.

I HEREBY CERTIFY, That I attended deceased from

19 to 2/9/28 19

that I last saw him alive on 2/6/28 19, and that death occurred, on the date stated above, at 9 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

CONTRIBUTORY (SECONDARY) Cerebral Hemorrhage

since 1/1/28 (duration) 74 days

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

6 DID AN OPERATION PRECEDE DEATH? NO DATE OF

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS? Chemical

(Signed) H. Williams, M. D.

, 19 (Address) Liberty, Mo. 64202

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Liberty, Missouri

DATE OF BURIAL

Feb. 11, 1928

20. UNDERTAKER

W. Meekhoff 1302 Faraon St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FEB 10 1928

