

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

Do not use this space.

30974

1. PLACE OF DEATH

County Muller
Township Caldess
City Caldess (No. _____) St. _____ Ward _____

Registration District No. 561
Primary Registration District No. 4320

File No. _____
Registered No. 53

2. FULL NAME

William J. Allee
(a) Residence. No. _____ St. _____ Ward _____
(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

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 2-18-1848

7. AGE YEARS MONTHS DAYS IF LESS than day, or _____
79 | 7 | 17

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmers Retail
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Muller Co, MO
(STATE OR COUNTRY)

10. NAME OF FATHER Wilson Allee

11. BIRTHPLACE OF FATHER (CITY OR TOWN) MO
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary McCasland

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) MO
(STATE OR COUNTRY)

14. INFORMANT Mason Allee
(Address) Caldess

15. FILED 10-10-27 1927 Belle Haynes
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-2 1927

17. I HEREBY CERTIFY, That I attended deceased from 10/1/26 to 10/2/27 1927 that I last saw him alive on 10/1/27 1927, and that death occurred, on the date stated above, at 1:20 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis
131
99 1290
(duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY arterio Sclerosis
(SECONDARY)
(duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) W. Allee, M. D.

. 19 (Address) Caldess Mo

*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

Caldess Cemetery DATE OF BURIAL 10/3 1927

20. UNDERTAKER W. G. Pully ADDRESS Caldess

N. B.—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.

