

Registration District No. **384**

Primary Registration District No. **4227**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Newell**
 (b) City or town **West Plains, Mo**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Jackson Str. 2**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community _____ years, months or days)

8. (a) PRINT FULL NAME **Louella Allison**

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex **FE** 5. Color or race **BLK** 6. (a) Single, widowed, married, divorced **M**

6. (b) Name of husband or wife **Demitt Allison** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **6-18-1898**
 (Month) (Day) (Year)

8. AGE: Years **41 1/2** Months **10** Days _____ If less than one day hr. _____ min.

9. Birthplace **West Plains, Mo**
 (City, town, or county) (State or foreign country)

10. Usual occupation **House work**

11. Industry or business _____

12. Name **Will Munn**

18. Birthplace **unk**
 (City, town, or county) (State or foreign country)

14. Maiden name **Melinda Stuart**

15. Birthplace **unk**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Demitt Allison**

(b) Address **West Plains, Mo**

17. (a) _____ (b) Date thereof **4-13-40**
 (Burial, exhumation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sadie Brown**

18. (a) Signature of funeral director **Robertson Munday**
 (b) Address **West Plains, Mo 241**

19. (a) **4-13-40** (b) **Vida W. Simons**
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Newell**
 (c) City or town **West Plains**
 (If outside city or town limits, write "RURAL")
 (d) Street No. **Jackson Str.**
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **11**
 year **1940** hour **10** minute **55 P.M.**

21. I hereby certify that I attended the deceased from **3/29**
 _____, 1940, to **4/11**, 1940

that I last saw her alive on **4/11**, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death **Supercardiac**

Due to **Pericarditis**

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

while at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature **Maurice Hampton** (M. D. or other) **MD**
 Address **West Plains** Date signed **4/24/40**

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

83 3

Thompson

127

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.....

....., Registered Apprentice No.....
working under my personal supervision.

RECEIVED

District Health Officer No. 5,

District File Number. 570 534

Date Filed 5/10/40

Signed L. A. Robinson

Licensed Embalmer No. 3432

P. O. Address West Plains, 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15-035

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 384

Primary Registration District No. 4227

Registrar's No.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Howell

(b) City or town West Plains
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Lonella Allison

(b) If veteran, name war _____

(c) Social Security No. _____

4. Sex 7 5. Color Black 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased 6 11 1898
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>41</u>	<u>42</u>	<u>10</u>	min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

{ 13. Birthplace _____
(City, town, or county) (State or foreign country)

{ 14. Maiden name _____

{ 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 4-13-40 (b) Vida W. SIMONS
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U.S.A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 11
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

WHEN at work? _____
(Specify type of place)

(e) Means of injury _____

23. Signed Marjorie Thompson (M. D. or other) _____
Address West Plains Date signed _____

SUPPLEMENTAL

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15035-7

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 384

Primary Registration District No. 4227

Registrar's No.

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

1. PLACE OF DEATH:

(a) County: Howell
(b) City or town: West Plains
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.
In this community years, months or days (Specify whether)

3. (a) PRINCE FULL NAME: Louella Allison
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex: 7
5. Color: B
6. (a) Single, widowed, married, divorced: m
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive: year
7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years: 41, Months: 10, Days, If less than one day: hr. min.

9. Birthplace: (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace: (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace: (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4, day 11, year 1940, hour, minute, M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw h. alive on and that death occurred on the date and hour stated above.

Immediate cause of death

Surgical Shock
Due to Peritonitis

Due to Mysteria

Other conditions: Uterine Fibroids (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy: 547

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature (M. D. or other)

Address Date signed