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-39
23159

Registration District No. 213 Primary Registration District No. 3014

1. PLACE OF DEATH:
(a) County Cole
(b) City or town Jefferson City
(c) Name of hospital or institution: 10 S. W. Main
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community years, months or days)

3. (a) PRINT FULL NAME James Robert Allison
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Emma 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased July 6 1891
(Month) (Day) (Year)

8. AGE: Years 49 Months 8 Days 18 If less than one day hr. _____ min. _____

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

10. Usual occupation Truck Business

11. Industry or business Self

MOTHER FATHER
12. Name John N. Allison
13. Birthplace Virginia
(City, town, or county) (State or foreign country)
14. Maiden name Mary Johnson
15. Birthplace Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Emma Allison
(b) Address 205 W. Main

17. (a) Burial (b) Date thereof Mar 25 1941
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Olean, Mo.

18. (a) Signature of funeral director James Lewis
(b) Address 280 Jefferson

19. (a) 3/24/41 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cole
(c) City or town Jefferson City
(If outside city or town limits, write "RURAL")
(d) Street No. 10 S. W. Main
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Mar day 24
year 1941 hour _____ minute 38 A.M.

21. I hereby certify that I attended the deceased from Mar 23 1941 to Mar 24 1941
that I last saw him alive on Mar 28 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Diabetic Coma
Due to Diabetes Mellitus

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

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? _____

23. Signature [Signature] (Specify type of place) _____
Address Jefferson City Mo. (City or town) (County) (State) Date signed 3/24/41

Physician
Duration 1 Day
13 1/2
Underline the cause to which death should be charged statistically.

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

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.

Signed..... *L. H. Anderson*

Licensed Embalmer No. *3641*

P. O. Address *Jefferson City*

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.