

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Washington Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Myckoff Clinic
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
In this community 10 yrs
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON
(c) City or town RAYTOWN (RURAL)
(If outside city or town limits, write "RURAL")
(d) Street No. 3 mi S, 1/4 WEST
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME ERNEST DEAN ALLISON

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife ETHEL M. ALLISON 6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased SEPT 9 1869
(Month) (Day) (Year)

8. AGE: Years 75 Months 0 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace DONT KNOW (City, town, or county) (State or foreign country) GA

10. Usual occupation FARMER

11. Industry or business _____

MOTHER FATHER

12. Name BEN ALLISON (City, town, or county) (State or foreign country) GA
13. Birthplace DONT KNOW (City, town, or county) (State or foreign country) DONT KNOW
14. Maiden name L. LEWIS (City, town, or county) (State or foreign country) GA
15. Birthplace DONT KNOW (City, town, or county) (State or foreign country) DONT KNOW

16. (a) Informant LEE'S SUMMIT
(b) Address LEE'S SUMMIT, MO ROUTE # 2

17. (a) BURIAL (b) Date thereof 9 16 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation LINWOOD, KANS.

18. (a) Signature of funeral director Lawrence Stausas
(b) Address Lawrence Stausas

19. (a) Sept 16-44 (b) Dr. Anna E. Hedge
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT day 13 year 1944 hour 8 minute 20 P.M.

21. I hereby certify that I attended the deceased from 9-9-44 to 9-13 1944; that I last saw him alive on 9-13 at 8:30 PM 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Acute Cardiac dilatation Duration 2 hrs.

Due to Shock following surgery for Strangulated Hernia 5 days.
Due to lost Gangrene intestinal wall.

Other conditions 122 lb
(Include pregnancy within 3 months of death)

Major findings: 4 ft of Colon gangrenous
Of operations Caused by rupture of muscles of the organ!
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? _____

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

23. Signature E. C. Myckoff (M. D. or other) _____
Address Grandview, Mo Date signed 9-13-44

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

4800

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.....

Licensed Embalmer No.....

P. O. Address.....

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.