

FILED DEC 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38220
Registrar's No. 10084

2009

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH
a. COUNTY _____
b. CITY OR TOWN St. Louis
c. LENGTH OF STAY (in this place) _____
d. FULL NAME OF HOSPITAL OR INSTITUTION Frisco Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission).
a. STATE Missouri
b. COUNTY Jackson
c. CITY OR TOWN Kansas City
d. STREET ADDRESS 5917 Walnut

3. NAME OF DECEASED
a. (First) Charles b. (Middle) Edward c. (Last) Allison

4. DATE OF DEATH (Month) (Day) (Year) 11-27-50

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH Oct. 13, 1883 9. AGE (In years last birthday) 67 IF UNDER 1 YEAR Months Days IF UNDER 12 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor 10b. KIND OF BUSINESS OR INDUSTRY Railroad 11. BIRTHPLACE (State or foreign country) Trenton, Mo. 12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Samuel Allison 13b. MOTHER'S MAIDEN NAME Emily Unknown 14. NAME OF HUSBAND OR WIFE Mae

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Mae Allison, Kansas City, Mo.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of sigmoid c. metastatic to urinary bladder
ANTECEDENT CAUSES (b) Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (c) Metastatic C. to peric.
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 2-1-49 19b. MAJOR FINDINGS OF OPERATION Carcinoma of sigmoid extending to bladder 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE No 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 153X

22. I hereby certify that I attended the deceased from 6 January, 1949, to 27 Nov, 1950, that I last saw the deceased alive on 27 Nov, 1950, and that death occurred at 10:15 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Genl W. Aldo M.D. 23b. ADDRESS 4966 Lochdale 23c. DATE SIGNED 27 Nov 50

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 11-27-50 24c. NAME OF CEMETERY OR CREMATORY _____ 24d. LOCATION (City, town, or county) (State) Kansas City, Mo.

DATE REC'D BY LOCAL REG. Nov 27 1950 REGISTRAR'S SIGNATURE J.B. Laster 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.

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

10084

121950

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

John J. Laines

Licensed Embalmer No. *4108*

P. O. Address *St. Louis 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, fact should be so stated above.