

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41686

STATE FILE NUMBER

FILED DEC 13 1957

318

1003

11453

Registration District No. Primary Registration District No. Registrar No.

|  |  |   |  |   |  |  |  |  |   |                                |  |
|--|--|---|--|---|--|--|--|--|---|--------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>                |  |  |  |  |   |                                |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>  |  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                         | c. CITY OR TOWN <b>St. Louis</b>  |  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |   |                                |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hospital</b>   |  |   |  | Length of stay in lb<br><b>1 day</b>  |  | d. STREET ADDRESS (If outside, give location)<br><b>3922 St. Louis Av.</b> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                    |   |                                |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>RHESA</b> Middle <b>JOHNSON</b> Last <b>ALLISTON, Sr.</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>Nov.</b> Day <b>27</b> Year <b>1957</b>  |  |  |  |  |   |                                |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Nov. 24, 1896</b>                                   |  | 9. AGE (In years last birthday)<br><b>61</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.<br>Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machinist</b>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Hussman Ref. Co.</b>   |   | 11. BIRTHPLACE (City and state or country)<br><b>Florence, Miss.</b> |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |                                |  |
| 13. FATHER'S NAME<br><b>William P. Alliston</b>  |  |   |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mattie Graves</b>                     |  |  |  |   |                                |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>Yes WW #1</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>489-07-3897</b>   |  | 17. INFORMANT Address<br><b>Bertha L. Alliston, 3922 St. Louis</b>         |  |  |   |                                |  |
| 18. CAUSE OF DEATH [Enter only one cause or line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b>                                      |  |   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |   |                                |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   |  | DUE TO (b)  |  | DUE TO (c)  |  |  |  |  |   |                                |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br><b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |                                |  |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>450.0</b> |   |  |  |  |  |   |                                |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a. m. p. m.  |  |   |  |   |  |  |  |  |   |                                |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) |  |   | 20f. CITY, TOWN, OR LOCATION COUNTY STATE                            |  |  |  |   |                                |  |
| 21. I attended the deceased from _____ to _____ and last saw her alive on _____<br>Death occurred at <b>9:00 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |   |  |  |  |  |   |                                |  |
| 22a. SIGNATURE<br><b>James M. Kelly Embaler</b>  |  |   |  | 22b. ADDRESS<br><b>1300 Clark</b>   |  |  |  | 22c. DATE SIGNED<br><b>11-29-57</b>  |   |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPC/19)<br><b>Removal</b>   |  | 23b. DATE<br><b>11-30-57</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park Cemetery</b>   |  |  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Normandy, Missouri</b>                               |   |                                |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>WHITE CHAPEL, FERGUSON, MISSOURI</b>  |  |   |  |   | 25. DATE RECD. BY LOCAL REG.<br><b>NOV 29 57</b>                     |  | 26. REGISTRAR'S SIGNATURE<br><b>J. Carl Smith, M.D.</b>                              |  |   |                                |  |

(Licensed Embalmer's Statement on Reverse Side)

Health, & Welfare  
S. Public Health Service  
S. 300  
v. 1-56  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.  
securing the medical certification in the same manner required by T-3. 140 WORKS 1949.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 \_\_\_\_\_  
Signature of Student Embalmer

Signed Eleana Province

Licensed Embalmer No. 3403

P. O. Address Jennings, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.