

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-009742
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 002
FILED MAR 28 1962

Primary Registration District No. 4009 Registrar's No. 17

VS 300
Rev. 4/59

10020

20020

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Andrew</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Andrew</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Savannah</u>			Length of stay in 1b		c. CITY OR TOWN <u>Savannah</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>310 West Market</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>310 West Market</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Agnes</u> Last <u>Allison</u>			4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1962</u>					
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-18-67</u>	9. AGE (last birthday) <u>94</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (City and state or country) <u>Savannah, Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>		
13a. FATHER'S NAME <u>Gottfried Kolbrenner</u>			13b. MOTHER'S MAIDEN NAME <u>Catharine E. Baum</u>		14. NAME OF HUSBAND OR WIFE <u>Robert Allison</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>- - -</u>		17. INFORMANT <u>Marie Allison, Savannah, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>	
IMMEDIATE CAUSE (a) <u>Cardiac decompensation with myocardial insufficiency</u>								
DUE TO (b) <u>Cardio-vascular renal disease</u>								
DUE TO (c) <u>Generalized Arterio-Sclerosis</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input 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.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		Month, Day, Year						
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 <u>7-30-56</u>		to <u>3-7-62</u>		and last saw her <u>alive</u> on <u>2-26-62</u>		Death occurred at <u>10:30 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <u>Lillian B. Kelley</u>				22b. ADDRESS <u>Savannah, Mo.</u>		22c. DATE SIGNED <u>3-9-62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>3-10-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Savannah Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Savannah, Missouri</u>		
24. FUNERAL DIRECTOR <u>BREIT & HAWKINS</u>			ADDRESS <u>SAVANNAH</u>		25. DATE RECD. BY LOCAL REG. <u>3-12-62</u>		26. REGISTRAR'S SIGNATURE <u>Lillian Sparks, Reg</u>	

USE BLACK INK
OR
TYPEWRITER RIBBON

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 James B. Hankin
Licensed Embalmer No. 4536

P. O. Address Savannah

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.