

JUN 15 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

23334  
Do not use this space.

1. PLACE OF DEATH  
 (a) County St. Louis Registration District No. 784  
 (b) Township Carondelet Primary Registration District No. 200  
 (c) City St. Louis (d) Street No. Koch Hosp. Registered No. 1068  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME ALLEN, AGNES  
 (a) Residence, No. 9932 N. 25th St. St. Louis, Mo. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Clarence Allen

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 9-29-03

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
35 9 16

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Shoe Work  
 9. Industry or business in which work was done, as saw mill, bank, etc. Shoe Mfg.  
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation 14 yrs.

FATHER 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kende, Mich  
 13. NAME Emil Klee  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Michigan

MOTHER 15. MAIDEN NAME Mabel Santhany  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Michigan

17. INFORMANT (ADDRESS) Koch Hosp. Records

18. BURIAL, CREMATION, OR REMOVAL PLACE PARK RIVER DATE JUNE 16 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Edw. F. Howard + Son 421 E St. Louis, Mo.

20. FILED JUN 15 1939 R. Meyer M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-15-1939

22. I HEREBY CERTIFY, That I attended deceased from 6-10-1939 to 6-15-1939  
 I last saw her alive on 6-15-1939. Death is said to have occurred on the date stated above, at 3 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Pulmonary Tuberculosis  
Bronchopneumonia  
fraternal

Other contributory causes of importance:  
fraternal

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? Sputum +. Was there an autopsy? No.

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? No.  
 If so, specify \_\_\_\_\_  
 (Signed) Bernard Friedman, M. D.  
 (Address) Koch Hosp, Koch, Mo.

Date of onset 11.3.34

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**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, above space should be left blank.**