

7-44
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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 12 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42102
Registrar's No. 11225

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Mo. 6 Days
(Specify whether _____)
In this community 27 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
St. Louis
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. 1455 Chouteau Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME

Thomas Allen 450

3. (b) If veteran, name war

none

3. (c) Social Security No.

Unknown

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

Ella

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased

April 15, 1889
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>50</u>	<u>8</u>	<u>13</u>	hr. _____ min. _____

9. Birthplace

New York City, New York
(City, town, or county) (State or foreign country)

10. Usual occupation

Chef
Restaurant

11. Industry or business

MOTHER FATHER {
12. Name Unknown ?
13. Birthplace Unknown ?
(City, town, or county) (State or foreign country)
14. Maiden name Unknown ?
15. Birthplace Unknown ?
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature

Thomas Allen

(b) Address

1455 Chouteau Ave

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 12/30/39
(Month) (Day) (Year)

(c) Place: burial or cremation

St. Matthews Cem

18. (a) Signature of funeral director

C. W. McFarland

(b) Address

2301 Lafayette Ave

19. (a)

DEC 30 1939 J. P. Breda
(Date recorded) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 29,
year 1939 hour 6:20 minute _____ P. _____ M. _____

21. I hereby certify that I attended the deceased from November 23, 1939, to December 29, 1939,
that I last saw him alive on December 29, 1939,
and that death occurred on the date and hour stated above.

Immediate cause of death

Septicemia - staph

Due to

Prostatic abscess
(Staphylococcus aureus)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

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

22. Signature Kenneth J. Carter (M. D. or other)
Address 1515 Lafayette, Date 12/30/39

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 Paula Keith

Licensed Embalmer No. 3612

P. O. Address 2317 Lafayette

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.