

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22758
Registrar's No. 1180

Registration District No. 784 Primary Registration District No. 101

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 month 2 days
In this community 13 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

Carrie Allen 450

3. (b) If veteran, name war ?

8. (c) Social Security No. ?

4. Sex female

5. Color or race colored

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

6. (b) Name of husband or wife Alfred Allen

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

7. Birth date of deceased Feb. 9 1881
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>4</u>	<u>8</u>	hr. _____ min.

9. Birthplace Unknown Ark.
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER

12. Name Mose Peay

13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Susie Unknown

15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Alfred Allen

(b) Address Woodlawn Ave. Robertson

17. (a) Burial (b) Date thereof 6-23-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Pk. Cem.

18. (a) Signature of funeral director Boyd Strick

(b) Address 1218 S. 1st St. St. Louis

19. (a) JUN 21 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17
year 1940 hour 6 minute :40 P.M.

21. I hereby certify that I attended the deceased from 5-15-40
_____ 19____, to 6-17-40 _____ 19____;
that I last saw her alive on 6-17-40 _____ 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Congestion
Myocardial Insufficiency
Due to Hypertension Heart disease
Due to Hypertension
Other conditions (include pregnancy within 3 months of death) 66d

Duration
2 d
??
10 yrs.
27 yrs.
PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings: Thyroid Enlarged
Of operations Absent
Of autopsy _____

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 _____

23. Signature [Signature] (M. D. or other) M.D.
Address St. Louis Co. Hosp. Date signed _____

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

6
29

OCT 26 1944

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.