No. 2
4-13-40
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 25 1940 91

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27359

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 7255

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G. Phillips Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County 18
(c) City or town St. Louis Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 3434 Clark
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME James Lee Allen 150
3. (b) If veteran, name war _____
3. (c) Social Security No. _____
4. Sex Male
5. Color or race Negro
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 7-29-40 (Month) (Day) (Year)
8. AGE: Years _____ Months _____ Days _____ If less than one day 6 hr. 20 min.
9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
10. Usual occupation ---
11. Industry or business _____
MOTHER FATHER
12. Name James Allen
13. Birthplace Ark. (City, town, or county) Ark. (State or foreign country)
14. Maiden name Lillie V. Johnson
15. Birthplace Hollygrove, Ark. (City, town, or county) (State or foreign country)
16. (a) Informant E. M. Sherard
(b) Address 2601 N Whittier
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-40 (Month) (Day) (Year)
(c) Place: burial or cremation City Cemetery
18. (a) Signature of funeral director J. B. Hamilton
(b) Address City Health Dept
19. (a) AUG 28 1940 (Date received local registrar) (b) J. B. Bullock (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 29 year 40 hour 6 minute 30 A.M.
21. I hereby certify that I attended the deceased from 7-29- 1940, to 7-29- 1940; that I last saw him alive on 7-29-40 19____; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Autopsy (Prematurity)	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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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? _____ (Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature G. E. Gease (M. D. or other)
Address 2601 N Whittier St. Date signed 8-24-40

(Licensed Embalmer's Statement on Reverse Side)

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 wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.