

**FILED MAR 26 1945**

Registration District No. **377**

Primary Registration District No. **6076**

Registrar's No. **674**

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

006

1. PLACE OF DEATH:

(a) County **St. Louis**  
(b) City or town **Manchester**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Manchester Nursing Home 4**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community.....  
years, months or days

3. (a) PRINT FULL NAME: **Frank Allen**

3. (b) If veteran, name war **NO** 3. (c) Social Security No. **NONE**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Divorced**

6. (b) Name of husband or wife **Emma S. Allen** 6. (c) Age of husband or wife if alive **70** years

7. Birth date of deceased **November 5 1864**  
(Month) (Day) (Year)

8. AGE: Years **80** Months **5** Days **6** If less than one day hr. min.

9. Birthplace **?** **Ohio**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Motorman**

11. Industry or business

12. Name **John Allen**

13. Birthplace **?** **Ohio**  
(City, town, or county) (State or foreign country)

14. Maiden name **Lydia M. Wolfard**

15. Birthplace **?** **Ohio**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Bessie Thrope**

(b) Address **6179 Bertha Ave**

17. (a) **FBurial** (b) Date thereof **Mar 14 1945**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Circleville Ohio**

18. (a) Signature of funeral director **Jos. W. Clark**

(b) Address **1125 Hodiamont Ave**

19. (a) **MAR 13 1945** (b) **E. G. McCarver, M.D.**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**  
(c) City or town **Wellston 91**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **6179 Bertha Ave**  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **11**  
year **1945** hour **9** minute **00** P.M.

21. I hereby certify that I attended the deceased from **Nov. 11**  
19 **44** to **March 11** 19 **45**  
that I last saw h. **to** alive on **March 9** 19 **45**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis + cerebral thrombosis**  
**secondary arteriosclerosis**  
Due to.....  
Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

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 **D.**

Signature **A. J. Mollen** (M. D. or N. M. D.)  
Address **35 W. Poloma** Date signed **3-12-45**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Dr. Merklin

~~442~~ ~~Dr. Merklin~~ ~~1863~~ ~~1863~~

2 1945

3507 Potomac

Gr 1863

any time after 5 oclock Monday

Evening

**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..... *W. W. Wilkin*.....

Licensed Embalmer No..... *2575*.....

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, fact should be so stated above.**