

3. No. 2
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5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED NOV 24 1946

Registration District No. 37

Primary Registration District No. 8063

Registrar's No. 3207

1. PLACE OF DEATH:

(a) County St. Louis County

(b) City or town Clayton, Missouri
(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 16 days
(Specify whether _____)

In this community 37 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Brentwood
(If outside city or town limits, write "RURAL")

(d) Street No. 8747 Rose Avenue
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM ALLEN

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race col. 6. (a) Single, widowed, married, divorced wid.

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

7. Birth date of deceased 9 11 65
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

81	1	20	hr. min.
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9. Birthplace Tennessee
(City, town, or county) (State or foreign country)

10. Usual occupation Minister

11. Industry or business _____

MOTHER FATHER { 12. Name Albert Allen

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

14. Maiden name Mary Cage

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

16. (a) Informant Mollie McClendon (sister)

(b) Address Brentwood, Mo

17. (a) (Burial, cremation, or removal) _____ (b) Date thereof 11-4-46
(Month) (Day) (Year)

(c) Place: burial or cremation Washington, Paris

18. (a) Signature of funeral director Peoples Union Co.

(b) Address 3100 Franklin Ave

19. (a) 11-2-46 (b) Wm J. Allen
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 31
year 1946 hour 11 minute 40 a M.

21. I hereby certify that I attended the deceased from October 16th 1946 to Oct. 31st 1946, that I last saw h. im alive on October 31 46 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Pneumo pneumonia

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____

"Of operations" _____

"Of autopsy" _____

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 _____

23. Signature Wm J. Allen (M. D. or other) U
Address _____ Date signed 11/4/46

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

3033

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

John H. Peters
.....
Licensed Embalmer No. *1184*
.....
P. O. Address *H. Lewis, N.*
.....

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.