

3. No. 2
12-45
5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 11 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5954
2054
Registrar's No. 100

Registration District No. 318 Primary Registration District No. 100

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

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
ST. LOUIS CITY HOSPITAL, MAX STARKLOEF
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution newborn
(Specify whether MEMORIAL)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4337 Hunt Ave.,
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME PIRANOVY ALLEN

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

4. Sex Male 5. Color or race white

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

7. Birth date of deceased: December 14th, 1946
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 1, year 1947 hour 2:05 minute A M.

21. I hereby certify that I attended the deceased from 12-14-46 to 2-1-47, 19____, to 2-1-47, 19____, that I last saw h im alive on 2-1-47, 19____, and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
		<u>1</u>	<u>17</u>	hr. _____ min. _____

Immediate cause of death

1. Chronic Hypoglycemia - etiology undetermined - 20 days

Due to 2. Lateral & Sagittal Sinus Thrombosis

Due to 3. Diarrhea, chronic

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

9. Birthplace: St. Louis City Hospital
(City, town, or county) (State or foreign country)

10. Usual occupation nil

11. Industry or business _____

MOTHER FATHER { 12. Name: Unknown

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

14. Maiden name: Arlene Allen

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

Major findings: _____

Of operations: _____

Of autopsy: _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant: M. Renard

(b) Address: St. Louis City Hospital

17. (a) Anatomical Board (b) Date thereof: 2-13-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Washington

18. (a) Signature of funeral director: W. R. Kelly

(b) Address: 3500 Ridge St

19. (a) FEB 27 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

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: 1515 LAFAYETTE (M. D. or other) _____

Date signed: 2-1-47

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, fact should be so stated above.