

S. No. 300
M-10-47
v. 5-17-39
I 3906

FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

30808
State File No. _____
Registrars No. **8334**

FILED OCT 9 1948
318
Registration District No. _____

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County **St. Louis**
(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 Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 days**
In this community **35 Years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **000 13**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **2231 Hickory**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Andrew Allen**
3. (b) If veteran, name war _____
3. (c) Social Security No. **491-18-3413**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept.** day **22**
year **1948** hour **1** minute **10 a** M.
21. I hereby certify that I attended the deceased from **Sept. 19 48** to **Sept. 22 48**
that I last saw him alive on **Sept. 22 48**
and that death occurred on the date and hour stated above.

4. Sex **Male 2** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Lillie Allen** 6. (c) Age of husband or wife if alive **44** years
7. Birth date of deceased **August 11, 1900**
(Month) (Day) (Year)

Immediate cause of death **LUNGS — Lobar Pneumonia, right lower**
Due to _____
Due to _____
Other conditions **Liver - Congestion**
(Include pregnancy within 3 months of death)

8. AGE: Years **48** Months **I** Days **II** If less than one day hr. min.

Major findings: Of operations _____
Of autopsy **Yes**
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

10. Usual occupation **SilverSmith**
11. Industry or business **St. Louis Metalcrafts Inc.**

MOTHER FATHER
12. Name **Andrew Allen**
13. Birthplace **Unknown Mississippi**
14. Maiden name **Zella Madden**
15. Birthplace **Unknown S.C.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Lillie Allen**
(b) Address **2231 Rear Hickory Street**

17. (a) **Burial** (b) Date thereof **9/28/48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Green Wood Cemetery**

18. (a) Signature of funeral director **J. J. Brudeck**
(b) Address **3615-17 Easton Avenue**

19. (a) **SEP 24 1948** (b) **J. J. Brudeck**
(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) (d) Means of injury _____
23. Signature **Osceola J. Daniels** (M. D. or other) _____
Address **2601 N Whittier** Date signed **9/23/48**

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 Jeffrey E. Cooper

Licensed Embalmer No. 4600

P. O. Address 4654 Cottage Ave

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.