

FILED APR 15 1949

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 3164

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		17			
d. FULL NAME OF HOSPITAL OR INSTITUTION CITY SANITARIUM				d. STREET ADDRESS (If rural, give location) 5609 MICHIGAN					
3. NAME OF DECEASED (Type or Print) a. (First) MARY		b. (Middle) E.		c. (Last) ALLEN		4. DATE OF DEATH (Month) (Day) (Year) April 4, 1949			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW		8. DATE OF BIRTH MAY 17 1866		9. AGE (In years last birthday) 82	10. MONTHS 10		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WIDOW		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME JAMES STUART			13b. MOTHER'S MAIDEN NAME MARY LANNER			14. NAME OF HUSBAND OR WIFE —			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS JOHN ALLEN R.R. 2 SULLIVAN MO					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Senility. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 19a. DATE OF OPERATION				INTERVAL BETWEEN ONSET AND DEATH 1948X	
19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from April 1, 1949, to April 4, 1949, that I last saw the deceased alive on APR. 4, 1949, and that death occurred at 1.45a m., from the causes and on the date stated above.									
23a. SIGNATURE John C. Crance M.D.				23b. ADDRESS 1515 Lafayette St. St. Louis, Mo		23c. DATE SIGNED 4/4/49			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE APRIL 6 1949		24c. NAME OF CEMETERY OR CREMATORY FESTUS		24d. LOCATION (City, town, or county) (State) MO			
DATE REC'D BY LOCAL REGS APR 4		REGISTRAR'S SIGNATURE J. B. Lanner		25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis		ADDRESS 2906 Garwood			

(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed Sam C Hill

Signed _____
Student Embalmer

Licensed Embalmer No. 4347

P. O. Address 2706 Travis

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.