

FILED NOV 10 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34880

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 9333	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Louis State Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>2514 E 2nd No 14</u>			
3. NAME OF DECEASED a. (First) <u>BLANCHE</u> b. (Middle) _____ c. (Last) <u>ALLEN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 2, 1949</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Separated</u>		8. DATE OF BIRTH <u>10-16-1883</u>	
9. AGE (In years last birthday) <u>66</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Phil</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Miss 1</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Wm Parks</u>		13b. MOTHER'S MAIDEN NAME <u>Betty Whalms</u>		14. NAME OF HUSBAND OR WIFE <u>Curtis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>St Louis State Hospital</u> ADDRESS _____			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardiac Decompensation</u> DUE TO (c) <u>Uremia due to</u> 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertensive Cardio Vascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>9/21/49</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>4</u>				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) <u>95</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>11:30 AM</u>			
22. I hereby certify that I attended the deceased from <u>Sept 2, 1942</u> , to <u>Oct. 2, 1949</u> , that I last saw the deceased alive on <u>Oct. 2, 1949</u> , and that death occurred at <u>5:15a</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>H. K. Busch, M.D.</u> (Degree or title)				23b. ADDRESS <u>5400 Arsenal St.</u>		23c. DATE SIGNED <u>10/3/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <u>Oct 31 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>		24d. LOCATION (City, town, or county) (State) _____	
DATE REC'D BY LOCAL REG. <u>Oct 31 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Lusater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Rowland Mortuary Service Inc.</u>			

(Licensed Embalmer's Statement on Reverse Side)

St. Louis 10, Mo.

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.

Student
Student Embalmer

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.