

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17690**

FILED MAY 19 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4214**

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		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2059	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital		d. STREET ADDRESS (If rural, give location) 5366 Cabanne Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Effie b. (Middle) c. (Last) Allen			4. DATE OF DEATH (Month) (Day) (Year) May 5, 1952			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH About 1863	9. AGE (In years last birthday) 88?	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) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and State or Foreign Country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Kaiser McAllister	13b. MOTHER'S MAIDEN NAME Fanny Francis	14. NAME OF HUSBAND OR WIFE Charles
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Dr. L.R. Allen, 51 Cheyenne Ct.	ADDRESS
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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 Glendale, Mo.		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Vascular Renal Disease. DUE TO (c) Partial bowel obstruction (adhesions) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H4 2X

22. I hereby certify that I attended the deceased from **4/18**, 19**52**, to **5/5**, 19**52**, that I last saw the deceased alive on **5/4**, 19**52**, and that death occurred at **4:40 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE F. Bergman	(Degree or title) M.D.	23b. ADDRESS 3720 Washington	23c. DATE SIGNED 5/5/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 5-7-52	24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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DATE REC'D BY LOCAL REG. MAY 5 1952	REGISTRAR'S SIGNATURE J. Earl Smith, M.D., R.P.	25. FUNERAL DIRECTOR'S SIGNATURE Fred M. Williams, 4535 Washington	ADDRESS
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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 M. W. Rueter

Licensed Embalmer No. 4865

P. O. Address St Louis, Mo.

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.