

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **15415**  
Registrar's No. **4097**

FILED MAY 14 1953  
BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>St. Luke's Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>12 30 Kingsbury Pl. 2129</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Florence</b> b. (Middle) <b>York</b> c. (Last) <b>Allen</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>April 19, 1953</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>July 4, 1881</b>
9. AGE (In years last birthday) <b>71</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>Frank B. York</b>		13b. MOTHER'S MAIDEN NAME <b>Mary L. Hardaway</b>	14. NAME OF HUSBAND OR WIFE <b>William Russell Allen Jr</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>F. York Allen, 30 Kingsbury Pl.</b>
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Mesenteric Thrombosis</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Vascular hypertension</b> 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 <b>April 19 53</b>		19b. MAJOR FINDINGS OF OPERATION <b>Mesenteric thrombosis, gangrene of intestine</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>23 hours</b>	
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) (Min.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>444X</b>	
22. I hereby certify that I attended the deceased from <b>April 19, 1953</b> , to <b>April 19, 1953</b> , that I last saw the deceased alive on <b>April 19, 1953</b> , and that death occurred at <b>10:00 a.m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Harriet B. Grant M.D.</b>		23b. ADDRESS <b>114 N. Taylor Ave</b>	
23c. DATE SIGNED <b>4/20/53</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>4-22-53</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>APR 20 1953</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Carl Smith M.D. Wagoner Mortuary, 4911 Washington Blvd</b>	

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.....  
Signature of Student Embalmer

Signed.....  
*Elton R. Penick*

Licensed Embalmer No. *428*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.