

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10689**

FILED APR 7 1954

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **560** Registrar's No. **747**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kinloch		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kinloch	
d. FULL NAME OF HOSPITAL OR INSTITUTION 401 Lix Avenue		d. STREET ADDRESS (If rural, give location) 401 Lix Avenue	

3. NAME OF DECEASED (Type or Print) a. (First) Jannie	b. (Middle)	c. (Last) Allen	4. DATE OF DEATH (Month) (Day) (Year) March 20, 1954
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 12/20/1885	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months 3 Days 0	IF UNDER 24 HRS. Hours 0 Mins. 0
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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) Greenwood, S. C.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Eugenia Patton	14. NAME OF HUSBAND OR WIFE Aggie Allen
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Aggie Allen, 401 Lix Ave., Kinloch	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		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
	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) Arteriosclerosis Generalized		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c)	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION none	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)
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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
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22. I hereby certify that I attended the deceased from **3-20, 1954**, to **3-20, 1954**, that I last saw the deceased alive on **3-20, 1954**, and that death occurred at **9 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE M. D. Johnson	(Degree or title) M.D.	23b. ADDRESS Finney mo	23c. DATE SIGNED 3/24/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/25/54	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.	24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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DATE REC'D BY LOCAL REG. 3/25/54	REGISTRAR'S SIGNATURE Charles J. Gates	25. FUNERAL DIRECTOR'S SIGNATURE Charles J. Gates	ADDRESS 4107 Finney Ave.
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(Licensed Embalmer's Statement on Reverse Side)

No. 300
10-48
3-20-54
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

Arthur L. Williams

Licensed Embalmer No. 4221

P. O. Address 4107 Finney Avenue

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.