

FILED OCT 14 1954

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. **32628**
 BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 2305

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Castle Point</u> c. LENGTH OF STAY (in this place) <u>1 yr</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2317 Chambers Rd</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>Castle Point</u> No <u>20</u> d. Is residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> e. STREET ADDRESS (If rural, give location) <u>2317 Chambers Rd., H 000</u>		
3. NAME OF DECEASED (Type or Print) <u>RICHARD LYLE ALLEN</u> a. (First) b. (Middle) c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 30th, 1954</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>single</u>	8. DATE OF BIRTH <u>March 26th 1946</u>	9. AGE (In years last birthday) <u>8</u> If UNDER 1 YEAR: Months _____ Days _____ If UNDER 48 HRS: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school boy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>school</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Los Angeles, Calif</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Lyle Allen</u> 13b. MOTHER'S MAIDEN NAME <u>Mildred Hough</u> 14. NAME OF HUSBAND OR WIFE <u>none</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Lyle Allen, 2317 Chambers Rd.,</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, asphyxia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Metastases of Cancer to lungs</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>TERATO SARCOMA left Testis</u> DUE TO (c) _____		
19a. DATE OF OPERATION			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) _____ 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 <u>MAY 1, 1954</u> , to <u>SEPT 30, 1954</u> , that I last saw the deceased alive on <u>SEPT 29, 1954</u> , and that death occurred at <u>5.30 A.M.</u> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>James Eugene Lewis MD</u>		23b. ADDRESS <u>1325 SOUTH GRAND ST. LOUIS, MO</u>		23c. DATE SIGNED <u>9-30</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		24b. DATE <u>10/4/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Council Bluffs, Iowa.</u>	
DATE REC'D BY LOCAL REG. <u>10-1-54</u>		REGISTRAR'S SIGNATURE <u>Robert R. Donohue</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Diedrich Funeral Home, 8319 Halls Ferry</u> ADDRESS	

WRITE PLAINLY—USING UNFADEING 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.....
Signature of Student Embalmer

Signed *Robert M. Murray*

Licensed Embalmer No. *37491*

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.