

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 17 1954

State File No. **42133**
10993
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY 2199	
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis, Mo.		c. CITY OR TOWN St. Louis,	d. Is Residence within limits of a city or incorporated town? Yes XX No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital		STREET ADDRESS (If rural, give location) 19 4218 Westminster Pl.	

3. NAME OF DECEASED (Type or Print) a. (First) Ella b. (Middle) c. (Last) Allen	4. DATE OF DEATH (Month) (Day) (Year) Nov. 30, 1954
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 6, 1868	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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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) Hillsboro, Illinois,	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Thomas Standing	13b. MOTHER'S MAIDEN NAME Jane (Unknown)	14. NAME OF HUSBAND OR WIFE Maurice Allen
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.	16. SOCIAL SECURITY NO. Nil.	17. INFORMANT'S SIGNATURE OR NAME Maurice Allen	ADDRESS 4218 Westminster Pl.
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____		
	ANTECEDENT CAUSES DUE TO (b) <i>Senility</i> DUE TO (c) <i>Generalized Arterio sclerosis</i>		
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 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4500
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **12:22** p.m., from the causes and on the date stated above.

23a. SIGNATURE <i>Patric Taylor Carauer</i> (Degree or title)	23b. ADDRESS 1200 Clark	23c. DATE SIGNED 12 25 54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12-3-54	24c. NAME OF CEMETERY OR CREMATORY Local	24d. LOCATION (City, town, or county) (State) Hillsboro, Illinois,
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DATE REC'D BY LOCAL REG. DEC 2 1954	REGISTRAR'S SIGNATURE <i>Carl Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE Guy Mullen	ADDRESS Chapel, 5041 Delmar Blvd.
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(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed *G. W. Wilkinson*

Licensed Embalmer No. *35*

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.