

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6071**
Registrar's No. **1659**

No. 300
10.48

FILED MAR 5 1956

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

BIRTH NO. _____

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, Mo.**

c. LENGTH OF STAY (in this place) **45 yrs.**

c. CITY OR TOWN **St. Louis**

d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **BARNES HOSPITAL**

e. STREET ADDRESS (If rural, give location) **1159 Bayard Avenue** **21270**

3. NAME OF DECEASED
a. (First) **Delilah**
b. (Middle) **NMN**
c. (Last) **Allen**

4. DATE OF DEATH (Month) (Day) (Year) **February 14, 1956**

5. SEX **Female**

6. COLOR OR RACE **Negro**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Widowed**

8. DATE OF BIRTH **Unknown 1885**

9. AGE (In years last birthday) **Abt. 70**
IF UNDER 1 YEAR: Months _____ Days _____
IF UNDER 24 HRS.: Hours _____ Min. _____

10a. USUAL OCCUPATION (The kind of work done during most of working life, even if retired) **Housewife**

10b. KIND OF BUSINESS OR INDUSTRY **--**

11. BIRTHPLACE (City and State, or Foreign Country) **Pinkstaff, Illinois**

12. CITIZEN OF WHAT COUNTRY? **U. S. A.**

13a. FATHER'S NAME **? Mitchell**

13b. MOTHER'S MAIDEN NAME **? Cole**

14. NAME OF HUSBAND OR WIFE **Artter Allen**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No**
(If yes, give war or dates of service) **--**

16. SOCIAL SECURITY NO. **--**

17. INFORMANT'S SIGNATURE OR NAME **Ruffe Hooper**
ADDRESS **1159 Bayard Ave.**

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
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Cerebral Vascular Accident**

*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) **Arteriosclerotic Heart Disease**
DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH **15 yrs.**

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION **4200**

20. AUTOPSY? YES NO

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 NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from **Jan. 11, 1956** to **Feb. 14, 1956**, that I last saw the deceased alive on **Feb. 14, 1956**, and that death occurred at **9:00 AM.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **C. Vermillion, M.D.**

23b. ADDRESS **BARNES HOSPITAL**

23c. DATE SIGNED **2/14/56**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Removal**

24b. DATE **2/18/56**

24c. NAME OF CEMETERY OR CREMATORY _____

24d. LOCATION (City, town, or county) (State) **Carbondale, Illinois**

DATE REC'D BY LOCAL REG. **FEB 16 1956**

REGISTRAR'S SIGNATURE **Charles J. Gates**

25. FUNERAL DIRECTOR'S SIGNATURE **Charles J. Gates**
ADDRESS **4107 Finney Ave.**

(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 *Arthur L. Heilbard*

Licensed Embalmer No. *422*

P. O. Address *4107 Iowa*

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.