

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29157  
STATE FILE NUMBER  
7001

XC 18847786 SL 9384

FILED AUG 26 1957

Registration District No. 318 Primary Registration District 1003

Registrar's No. 7001

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, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA Hospital 914 No. 35</b>		Length of stay in lb <b>72 days</b>	d. STREET ADDRESS <b>2411 A North Sarah</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Frank Allen</b>			4. DATE OF DEATH <b>7-25-57</b>		
5. SEX <b>male</b>		6. COLOR OR RACE <b>negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-13-07</b>	9. AGE (In years last birthday) <b>49</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Yardman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (City and state or country) <b>Macon, Mississippi</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Henry Allen</b>			14. MOTHER'S MAIDEN NAME <b>Anna Cobbs</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>VA HOSPITAL RECORDS, ST. LOUIS, MO.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LYMPHOSARCOMA</b>					INTERVAL BETWEEN ONSET AND DEATH <b>UNK</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>-</b>					
DUE TO (c) <b>-</b>					<b>200.1</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>-</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <b>NONE</b>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <b>None</b> Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>5-14-57</b> to <b>7-25-57</b> and last saw <b>him</b> alive on <b>7-25-57</b> . I died occurred at <b>4:30 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
21a. SIGNATURE (Dr. or title) <b>H. Westphaelinger, M.D.</b>			21b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>		21c. DATE SIGNED <b>7-25-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. NAME OF CEMETERY OR CREMATORY <b>H. F. WESTPHELINGER, M. D. National Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks, Mo.</b>	
24. FUNERAL DIRECTOR <b>Charles J. Gates, 4107 Finney</b>		25. DATE RECD. BY LOCAL REG. <b>JUL 27 57</b>		26. REGISTRAR'S SIGNATURE <b>J. Earl Smith - M.D.</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-  
by me, or by ..... Student Embalmer No. ....  
working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Edward G. Flynn* .....  
Licensed Embalmer No. 4107

P. O. Address 4107 Finner

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. ( 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.**