Health, & Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-041225
STATE FILE NUMBER

FILED NOV 20 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10923

1. PLACE OF DEATH
a. COUNTY ~~St. Louis, City Hospital # 1~~
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS MO — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #I — Length of stay in 1b 25

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 2739 Thomas Street — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First ARABELLE Middle Last ALLEN

4. DATE OF DEATH Month Nov. Day II Year 1958

5. SEX Female 3
6. COLOR OR RACE Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 9/3/1902
9. AGE (In years last birthday) 56 — IF UNDER 1 YEAR Months 2 Days 8 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (City and state or country) Mississippi
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Freeman Fluellen
13b. MOTHER'S MAIDEN NAME Elizabeth Lemon
14. NAME OF HUSBAND OR WIFE John Allen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.
16. SOCIAL SECURITY NO. ?
17. INFORMANT Address John Allen, 2739 Thomas Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASTROCYTOMA OF LEFT FRONTAL
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Lobe; Cerebral, with LIQUIFACTION
DUE TO (c) + Necrosis — 193.0
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 7-29-58, to 11-11-58 and last saw her/him alive on 11-11-58
Death occurred at 2:30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John Allen Burrell (M.D.)
22b. ADDRESS 1515 LAFAYETTE AVE.
22c. DATE SIGNED 11/12/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 11/18/58
23c. NAME OF CEMETERY OR CREMATORY Washington Park
23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri

24. FUNERAL DIRECTOR ADDRESS Ellis Funeral Home, 2820 Stoddard St.
25. DATE RECD. BY LOCAL REG. NOV 13 '58
26. REGISTRAR'S SIGNATURE J Carl Smith MD MJB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Fulton E. Culkin

Licensed Embalmer No. 4198

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.