

FEDERAL BUREAU OF INVESTIGATION - STANDARD CERTIFICATE OF DEATH

59-030204

FILED VS AUG 24 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 7398** STATE FILE NUMBER

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Louis</b>                       |  | Length of stay in 1b<br><b>70 yrs.</b>   | c. CITY OR TOWN <b>St. Louis</b><br>Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Hamilton Nursing Home</b> |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>339 N. Taylor, Avalon Hotel</b><br>Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|---|---------------------------|--|---|---|--|
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mrs. GERTRUDE</b> Middle <b>CHASE</b> Last <b>ALLEN</b>         |                           |  | 4. DATE OF DEATH<br>Month <b>August</b> Day <b>7</b> Year <b>1959</b>               |   |  |
| 5. SEX <b>F</b>   | 6. COLOR OR RACE <b>W</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/16/74</b>   | 9. AGE (last birthday)<br><b>84</b>                   | IF UNDER 1 YEAR<br>Months _____ Days _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   | 11. BIRTHPLACE (City and state or country)<br><b>Haverhill, Mass.</b>               | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>             |  |
| 13a. FATHER'S NAME<br><b>Unknown</b>  |                           | 13b. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |   | 14. NAME OF HUSBAND OR WIFE<br><b>Walter L. Allen</b> |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)        |                           | 16. SOCIAL SECURITY NO.<br><b>None</b>   | 17. INFORMANT<br><b>Mrs. Russel J. Kauffman</b><br>Address <b>5841 Cabanne (12)</b> |   |  |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Natural causes undetermined</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days</b> |
| DUE TO (b) <b>Probable lung embolus</b>  |  | <b>7 days</b>                                     |
| DUE TO (c) <b>Advanced general arteriosclerosis</b>  |  | <b>10 years</b>                                   |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Arteriosclerotic Convulsions - 5 years +</b><br><b>Terminal pneumonia - Total deafness 2 yr +</b> |  | 450.0 | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
|---|--|-------|---|

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| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBES HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |   |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.   | 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 **1934**, to **August 7 1959** and last saw her alive on **Aug 7, 1959**  
Death occurred at **3:10 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

|  |  |                                   |
|--|--|-----------------------------------|
| 22a. SIGNATURE (Degree or title)<br><b>J. Fred W. Clark M.D.</b> | 22b. ADDRESS<br><b>864 Hamilton Blvd St. Louis 12 Mo</b> | 22c. DATE SIGNED<br><b>8-7-59</b> |
|--|--|-----------------------------------|

|  |                             |   |  |
|--|-----------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b> | 23b. DATE<br><b>8/10/59</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bellefontaine Cemetery</b> | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Mo.</b> |
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| 24. FUNERAL DIRECTOR<br><b>Alexander &amp; Sons 6175 Delmar Blvd.</b> | 25. DATE RECD. BY LOCAL REG.<br><b>AUG 10 59</b> | 26. REGISTRAR'S SIGNATURE<br><b>Carl Smith 170</b> |
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DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

6969 9 I 018

APR 27 1960

STATEMENT BY LICENSED EMBALMER

FEB 8 1960

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed jos. E Mc Cullon

Licensed Embalmer No. 2760

P. O. Address C 175 Pll

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