URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS AUG 24 1960

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7881

60-031811
STATE FILE NUMBER

ENDED

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.

Length of stay in 1b: 5 WEEKS

c. CITY OR TOWN: ST. LOUIS

Inside Limits: Yes ☑ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Louis City Hosp. #1

Inside Limits: Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location): 762 HAMILTON

Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First Alice Middle Last Allred

4. DATE OF DEATH: Month 8 Day 9 Year 60

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐

8. DATE OF BIRTH: 9-9-1879

9. AGE (last birthday): 80

IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HR: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (City and state or country): CLAIRWELL MARTIN, MICHIGAN

12. CITIZEN OF WHAT COUNTRY: U.S.A

13a. FATHER'S NAME: CHARLES HOWARD

13b. MOTHER'S MAIDEN NAME: BIIVA – ?

14. NAME OF HUSBAND OR WIFE: WILLIAM P. ALLRED

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: WALTER R. CHEEVER Address: 1049 SOAIVIVA

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) pneumonia

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) aspiration of food

DUE TO (c) 491 x

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

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 7/2/60, to 8/9/60 and last saw her alive on 8/9/60

Death occurred at 6:35 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Jerome W. Shaye, M.D. (Degree or title)

22b. ADDRESS: 1515 Lafayette Avenue

22c. DATE SIGNED: 8/9/60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

23b. DATE: 8-10-60

23c. NAME OF CEMETERY OR CREMATORY: MISSOURI CREMATORY

23d. LOCATION (City, town, or county) (State): ST. LOUIS, MO

24. FUNERAL DIRECTOR: HOWARD H. MICHEL ADDRESS: 5930 SOUTHWEST

25. DATE RECD. BY LOCAL REG.: AUG 10 1960

26. REGISTRAR'S SIGNATURE: Noal Smith, M.D.

DOCUMENT

STATEMENT BY LICENSED EMBALMER

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_____
Not Embalmer

Licensed Embalmer No._____

P. O. Address_____

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