SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-010384
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2735

FILED MAR 30 1961

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, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI
Length of stay in Ib 102 DAYS

c. CITY OR TOWN ST. LOUIS
Inside Limits Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, 915 NORTH GRAND AVE.
Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 4124A PAGE BLVD.
Reside on Farm Yes ☐ No ☐

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

4. DATE OF DEATH Month 3 Day 20 Year 61

5. SEX MALE

6. COLOR OR RACE NEGRO

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH 5/22/03

9. AGE (last birthday) 57

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) BARBER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country) CARRIES MILL, ILLINOIS

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

13a. FATHER'S NAME ARLTER ALLEN

13b. MOTHER'S MAIDEN NAME DELILAH MITCHELL

14. NAME OF HUSBAND OR WIFE - - - - - -

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

16. SOCIAL SECURITY NO.

17. INFORMANT LAURA HARVELL (DAUGHTER) Address SEE #2

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) UREMIA — INTERVAL BETWEEN ONSET AND DEATH 4 DAYS

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

DUE TO (b) RENALARTERY THROMBOSIS — 2 DAYS

DUE TO (c) ARTERIOSCLEROSIS 450.0

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

VA

21. I attended the deceased from 12/8/60 to 3/20/61 and last saw him alive on 3/20/61

Death occurred at 12:30 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE PATRICK G. GRAHAM, (Degree or title) M.D.

22b. ADDRESS VAH, ST. LOUIS, MO.

22c. DATE SIGNED 3/20/61

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

23b. DATE 3/24/61

23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery

23d. LOCATION (City, town, or county) (State) St. Louis, Mo.

24. FUNERAL DIRECTOR Cunningham & Moore, ADDRESS 2405 Marcus

25. DATE RECD. BY LOCAL REG. MAR 22 1961

26. REGISTRAR'S SIGNATURE Hoad Smith, M.D.

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

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 John K Cunningham

Licensed Embalmer No. 4476

P. O. Address 2405 Marcus

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.