

## OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046021

FILED DEC 27 1961

318

Primary Registration District No.

1003

Registrar's No.

11815

STATE FILE NUMBER

AMENDED

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		Length of stay in 1b	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bernard Nursing Home		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS 4475 West Pine Blv'd		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CARRIE ROBERTSON ALLEN			4. DATE OF DEATH Month Day Year December 18, 1961
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-19-1868
9. AGE (last birthday) 93		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) at home		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Nashville Tenn.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Theodore Robertson	
13b. MOTHER'S MAIDEN NAME Catherine Hariges		14. NAME OF HUSBAND OR WIFE F.M. Allen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. INFORMANT Mrs. Marion Ashcroft 4475 W. Pine	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Gen arteriosclerosis</u> DUE TO (c) <u>332x</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)			INTERVAL BETWEEN ONSET AND DEATH 3 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Respiratory infection</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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"/>	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 <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 <u>about April 1960</u> to <u>Dec 18, 1961</u> and last saw <sup>her</sup> alive on <u>Dec 18, 1961</u> . Death occurred at <u>12:10 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John L Horner</u>		22b. ADDRESS <u>114 N. Taylor St</u>	
22c. DATE SIGNED <u>12-18-61</u>		22d. ADDRESS <u>St Louis Mo</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE <u>Dec. 19, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Nashville Tenn</u>
24. FUNERAL DIRECTOR <u>C.R. Lupton and Sons 7233 Delmar Blv'd</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 19, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Lead Smith, M.D.</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF MAIL

Dr. John Horner  
Grant Clinic

**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

*Arnold W. Schoene*

Licensed Embalmer No.

*3864*

P. O. Address

*St. Louis, Mo.*

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.