MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

12862

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. 3405

Township ..... Primary Registration District No. 1003 Registered No. .....

City St. Louis (No. City Hospital ..... St. ..... Ward)

17793 **2. FULL NAME** Allen Quinn

(a) Residence. No. Municipal Lodging House St. 25 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Separated

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 12 - 1863

7. AGE: Years 66 | Months | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Illinois

PARENTS
10. NAME OF FATHER: Nor Known
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY)

14. INFORMANT: Hospital Information
(Address) E. Rowan City Hospital

15. FILED ..... 19 1929 Max C Starkeley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 7 1929

17. I HEREBY CERTIFY, That I attended deceased from Feb 25, 1929, to March 7, 1929 that I last saw him alive on March 7, 1929 and that death occurred, on the date stated above, at 12 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia

10th (duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (SECONDARY) 101 A (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? .....

3/7 (Signed) R Berg M. D
, 1929 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: St. Louis U.
DATE OF BURIAL: 3-13 1929

20. UNDERTAKER: Walter Richter
ADDRESS: 3500 Rutger St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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Curry.