

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

Do not use this space.

24343

1. PLACE OF DEATH

County.....
Township *St. Louis Mo.*
City *St. Louis Mo.* (No. *City Hosp # 2*)

Registration District No. **791**
Primary Registration District No. **1003**

File No.....
Registered No. **6477**
St..... Ward.....

2. FULL NAME

(*Harvey Allen*) *Harvey Allen*
(a) Residence. No. *3110 Jug* St. *21* Ward.....

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *12* 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 *Col* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *11-26-1878*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
51 11 26

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. *Chemical Worker*
(b) General nature of industry, business, or establishment in which employed (or employer). *Tube Tester*
(c) Name of employer *Monbonte Chemical Co.*

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

PARENTS
10. NAME OF FATHER *Charles Foster (Step)*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*
12. MAIDEN NAME OF MOTHER *Sarah Allen*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

14. INFORMANT *A. Gertrude Creath* (Address) *City Hosp # 2*

15. JUL - 3 1934 FILED *Max C. Stanley* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *7-2* 19 *30*

17. I HEREBY CERTIFY, That I attended deceased from *4-30*, 19 *30* to *7-2*, 19 *30* that I last saw *him* alive on *7-2*, 19 *30*, and that death occurred, on the date stated above, at *3:10* p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ch. Myocarditis
234
93C (duration) yrs. *6* mos. ds.

CONTRIBUTORY (SECONDARY) *Tuberculosis of Lungs* (duration) yrs. *6* mos. ds.

18. WHERE WAS DISEASE CONTRACTED *Home*

IF NOT AT PLACE OF DEATH.....
DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....
WAS THERE AN AUTOPSY? *No*
WHAT TEST CONFIRMED DIAGNOSIS? *X-ray*
(Signed) *H. H. Hatcher*, M. D.
7/3, 19 *30* (Address) *City Hosp # 2*

*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 *East. St. Louis* DATE OF BURIAL *7/6* 19 *30*

20. UNDERTAKER *Peoples Und. Co.* ADDRESS *3100 Franklin*

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.

