

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

DEPARTMENT OF COMMERCE

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27478

State File No.

6978

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town 3640 Marine, St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
U.S. Marine Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 mo. 5 days.
(Specify whether
In this community X
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town 1103 Jackson Pl. St. Louis, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. X (If rural, give location) 26
(e) If foreign born, how long in U. S. A.? Yes years.

3. (a) PRINT FULL NAME Lucious L. Allen 450

3. (b) If veteran, name war X 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Lilly Allen 6. (c) Age of husband or wife if alive X years

7. Birth date of deceased Aug. 25 1885
(Month) (Day) (Year)

8. AGE: Years 53 Months 11 Days 15 If less than one day hr. min.

9. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Oiler

11. Industry or business Aboard River Steamers

12. Name Clinton D. Allen
13. Birthplace X Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Emma Manning
15. Birthplace X Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Clinical Record
(b) Address US Marine Hospital, St. Louis, Mo.

17. (a) BURIAL (b) Date thereof AUG 12/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation INDIANA

18. (a) Signature of funeral director Phoalutis
(b) Address 2906 Grand Ave

19. (a) AUG 11 1939 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 10
year 1939 hour 6:20 PM minute _____ M.

21. I hereby certify that I attended the deceased from May 5, 1939
_____, 19____, to Aug. 10, 1939, 19____;
that I last saw him alive on May 10, 1939, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary, acute, military. Duration Unknown

Due to X
Due to X

Other conditions Phlebitis, acute, femoral
(Include pregnancy within 3 months of death) 6-23-39

Major findings:
Of operations None
Of autopsy No

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) No
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
(Specify type of place) (e) Means of injury _____

23. Signature J. P. Gesterle, A. Auburg, M.D.
Address US Marine Hospital, St. Louis, Mo. Date signed 1939

(Licensed Embalmer's Statement on Reverse Side)

Physician's Signature
Underline the cause to which death should be charged and statistics.

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.....

Thos Lute's

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Thos Lute's

Licensed Embalmer No. *1619*

P. O. Address *2906 Grove*

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 this body is not embalmed, above space should be left blank.