

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

16594
State File No. 4072
Registrar's No.

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town Saint Louis Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Saint John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME ACE ALEXANDER ALLEN 450

3. (b) If veteran, name war 498-10-2192 Unknown (c) Social Security No. Unknown

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

6. (b) Name of husband or wife Clara Allen 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased May 19 1896
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
43 11 16 hr. min.

9. Birthplace Greenville, Wayne Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
12. Name Allison Allen
13. Birthplace Wayne County Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth White
15. Birthplace Wayne County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Andrew Franklin Allen (Brother)

(b) Address Greenville Missouri

17. (a) Burial (b) Date thereof 5-6-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Silva Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd

19. (a) MAY 6 1940 (b) _____
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wayne
(c) City or town Greenville
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 5th
year 1940 hour 12 minute 50 P.M.

21. I hereby certify that I attended the deceased from May 3
1940, to May 5, 1940

that I last saw him alive on May 5, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the Liver

Duration

2 months

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Walter A. Dill (M., D. or other) MD.

Address 7346 Manchester Date signed 5/5/40

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

A. S. No. sent in by letter -
6-4-40 -

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed

Albert G. Hoffa

Licensed Embalmer No. *2991*

P. O. Address

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.