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MISSOURI STATE BOARD OF HEALTH
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27066**
Registrar's No. **6962**

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St Johns Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 wks.**
(Specify whether _____)
In this community **5 wks.**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Illinois** (b) County **Peoria**
(c) City or town **Dunlap** **NR**
(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.

3. (a) PRINT FULL NAME **Walter Hollis Allen 450**
(b) If veteran, name war **No**
(c) Social Security No. **No**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Aug** day **16**
year **1940** hour **1:10** minute **15 P.M.**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **married**
(b) Name of husband or wife **Fima** 6. (c) Age of husband or wife if alive **79** years
7. Birth date of deceased **Nov 22 1860**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **July 8th 1940** to **Aug 16 1940**
that I last saw him alive on **Aug 16 1940**
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
79 8 24 hr. min.

Immediate cause of death **Arteriosclerosis (Heart Disease)** Duration **1 yr**
Due to **Generalized Arteriosclerosis**

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

Other conditions **Hypertension (left), Chronic**
(Include pregnancy within 3 months of death)

10. Usual occupation **Physicien**

Major findings: **Cystic Debris - hyperten. left**
Of operations _____
Of autopsy _____

11. Industry or business _____

MOTHER FATHER
12. Name **William Allen**
13. Birthplace **Thompson Conn** (City, town, or county) (State or foreign country)
14. Maiden name **Sarah Nutt**
15. Birthplace **Manchester England** (City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant **Henry Allen**
(b) Address **Walter Allen 450**
17. (a) **Removal** (b) Date thereof **8-17-40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Dunlap Ill**

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

18. (a) Signature of funeral director **Chas A Gull**
(b) Address **4453 Washington**
19. (a) **AUG 17 1940** (b) **J T Fredrick**
(Date received local registrar) (Registrar's signature)

23. Signature **Alphonse M. Melan** (M. D. or other)
Address **301 Duane Bldg** Date signed **9/16/40**

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

5/20

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 *Howard A. Rowland*

Licensed Embalmer No. *3114*

P. O. Address *21 Kenner St. N.W.*

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, fact should be so stated above.

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STANDARD CERTIFICATE OF DEATH

State File No. *27066*

Registrar's No. *6962*

Registration District No.

Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County *St. Louis*
(b) City or town *St. Louis*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: *St. Johns Hosp.*
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(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.

3. (a) PRINT FULL NAME *Walter H. Allen*

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

4. Sex *m* 5. Color or race *w* 6. (a) Single, widowed, married, divorced *m*

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *10-24-40* (b) *J. F. Predeck*
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Aug.* Day *16* Year *1940*
hour _____ minute _____ M.

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

Immediate cause of death *Interosplenic H. Dis.*
left kidney
systemic thrombosis

Due to _____

D. *Hypertensive thromb. H.*
left kidney

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

Major findings: _____
Of operations _____

Of autopsy _____

Duration *1 yr + 6 mo*

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? _____
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

