

No. 1-4-41
5-17-39
X22950

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

MAY 6 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15768
Registrar's No. 914

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 784 Primary Registration District No. 101

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton
(c) Name of hospital or institution: St. Louis County Hospital
(d) Length of stay: In hospital or institution 1 mo. 5 days
In this community 9 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis
(c) City or town Wellston, Mo.
(d) Street No. 6550 Whitney Ave.
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME William H. Allbritten
(b) If veteran, name war World War I
(c) Social Security No 498-03-2526

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced married
(b) Name of husband or wife Mary Capstick
(c) Age of husband or wife if alive 33 years
7. Birth date of deceased Oct. 5 1897

8. AGE: Years 43 Months 6 Days 24

9. Birthplace Unknown Ky.

10. Usual occupation laborer

11. Industry or business Hi Point Moving & Storage

MOTHER FATHER { 12. Name Thomas Allbritten
13. Birthplace Unknown Ky.
14. Maiden name Eva Ramsey
15. Birthplace Unknown Ky.

16. (a) Informant Mary Allbritten
(b) Address 6550 Whitney

17. (a) Burial (b) Date thereof 5-1-41
(c) Place: burial or cremation St. Ferdinand Cem.

18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiament

19. (a) APR 30 1941 (b) R. Meyer (c) Registrar's signature

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 29
year 1941 hour 4 minute 30 A.M.
21. I hereby certify that I attended the deceased from 3-24-41
19 to 4-29-41
that I last saw him alive on 4-29-41
and that death occurred on the date and hour stated above.

Immediate cause of death Duodenal hemorrhage
Due to Duodenal ulcer
Other conditions 117 B

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?
(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 R. Keenan (M. D. or other)
Address Date signed

Duration 1 month
2 years
PHYSICIAN Underline the cause to which death should be charged statistically.

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

James W. Blah
.....
Licensed Embalmer No. *1661*

P. O. Address *1125 Hodiannon*

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.