

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22737

State File No.

6757

Registration District No.

818

Primary Registration District No.

1003

Registrar's No.

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:
Hasonic Home of Missouri 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution by 11 mos
(Specify whether
In this community
years, months or days)

3. (a) PRINT
FULL NAME Russell LaFayette Allen

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife Elizabeth Crowe 6. (c) Age of husband or wife if alive years

7. Birth date of deceased April 14, 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 3 10 hr. min.

9. Birthplace Cape Girardeau Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Minister

11. Industry or business

12. Name Jacob Allen
13. Birthplace Washington Co. Ill.
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Link
15. Birthplace Cape Girardeau, Mo. Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Iva Hirsch
(b) Address 5351 Delmar Blvd.

17. (a) Removal (b) Date thereof 7/25/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dexter, Missouri

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

(b) Address 4700 Washington Blvd.

19. (a) Ill 2-1943 (b) J. B. Bredech
(Date received from Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5351 Delmar Blvd.
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24
year 1943 hour 10:10 PM minute 0 M.

21. I hereby certify that I attended the deceased from 8-12-42
19 7-24 to 1943

that I last saw him alive on 7-24 19 43
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myo-
carditis Chronic Interstitial
nephritis
Due to 12 MOS

Due to

Other conditions
(include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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 Solomon (M. D. or other)
Address 508 N. Grand Date signed 7-25-43

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

MOTHER FATHER

6757

6757

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.....

W. Wilkinson

Licensed Embalmer No.....

3575

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, fact should be so stated above.