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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED FEB 1 1944**

STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

State File No. 9  
Registrar's No. 780

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:  
(a) County St. Louis, Missouri  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 15 days  
(Specify whether  
In this community 12 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County 000  
(c) City or town St. Louis, (If outside city or town limits, write "RURAL") 17  
(d) Street No. 13th & Carr (If rural, give location) 925  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Will Allen  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced 9  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Unknown Unknown  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month January day 9, year 1944 hour 3 minute 00 P. M.  
21. I hereby certify that I attended the deceased from December 25, 1943 to January 9, 1944; that I last saw him alive on January 9, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Right Hemiplegia Duration 10 days  
Due to Cerebro-vascular Disease Unk.

8. AGE: Years 51 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
9. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) 83  
Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

MOTHER FATHER { 12. Name Steve Thomas  
13. Birthplace Unknown Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Annie Bryant  
15. Birthplace Unknown Kentucky  
(City, town, or county) (State or foreign country)

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

16. (a) Informant Shirley Smith  
(b) Address 2601 N. Whittier Street  
17. (a) Burial (b) Date thereof JAN 27 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation CITY CEMETERY  
18. (a) Signature of funeral director H. Meschner  
(b) Address City Health Dept  
19. (a) JAN 26 1944 (b) J. F. Bredenk  
(Date received local registrar) (Registrar's signature)

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 S. E. Smith (M. D. or other) 1/11/44  
Address 2601 N. Whittier Date signed \_\_\_\_\_

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

**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.....

Licensed Embalmer No.....

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.**