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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 23 1945

Registration District No. 818

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 10956

Registrar's No. 3093

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: 5050a Delmar Blvd.
(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 Missouri (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5050a Delmar Blvd.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Flora Elliott Allen

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Thlophulus Allen

6. (c) Age of husband or wife if alive years

7. Birth date of deceased October (Month) 30 (Day) 1866 (Year)

8. AGE:	Years	Months	Days	If less than one day
	78	5	6	hr. min.

9. Birthplace Marion County (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Unknown Elliott
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

MOTHER
14. Maiden name Harriett Hoptkins
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)

16. (a) Informant Mrs. Seagrove
(b) Address 5050a Delmar Blvd.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-45 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) APR 6 1945 (Date received local registrar) (b) J. F. Biedeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6
year 1945 hour 2:00 minute A. M.

21. I hereby certify that I attended the deceased from March 1, 1945, to April 6, 1945
that I last saw her alive on April 4, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis

Due to myocarditis, Chr

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 Dr. Walton (M. D. or other)

Address Dr. Walton M.D. 5 96 N Taylor Date signed 4/6-45

(Licensed Embalmer's Statement on Reverse Side)

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.