V. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 3 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 21610

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 6352

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)
In this community 30 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3114 a Lawton
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Carrie Allen

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Female 3

5. Color or race Negro

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

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

6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased April 24, 1894 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
51	2	25	hr. min.

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

10. Usual occupation housewife

11. Industry or business

MOTHER FATHER

12. Name Lawerence Elliot

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

14. Maiden name unknown

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

16. (a) Informant Grandville Allen
(b) Address 3114 a Lawton

17. (a) Shipped (Burial, cremation, or removal) (b) Date thereof 8/24/45 (Month) (Day) (Year)
(c) Place: burial or cremation Vicksburg, Miss.

18. (a) Signature of funeral director Dunn Funeral Home
(b) Address 215 So. Jefferson Ave.

19. (a) JUL 23 1945 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 19 year 1945 hour 11 minute 00 A.M.

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

Immediate cause of death — Duration
Carcinoma of Lymph Gland
Due to Malnutrition
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

50

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

23. Signature Patrick E. Taylor (M.D. or other)
Address 1300 Clark Date signed 7-23-45

(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 S. J. Watson

Licensed Embalmer No. 2698

P. O. Address 7769 Montreal

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.