. S. No. 2
0M—5-43
ev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED DEC 12 1945

State File No. 35003

Registration District No. 318 Primary Registration District No. 1603 Registrar's No. 10524

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:
Jewish Hospital O
(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 17

(c) City or town St. Louis 12
(If outside city or town limits, write "RURAL")

(d) Street No. 5330 Pershing Ave.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME William P. Allred

3. (b) If veteran, name war Nil

3. (c) Social Security No.

4. Sex Male O

5. Color or race White

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

6. (b) Name of husband or wife Alice B. Allred

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased September (Month) 1 (Day) 1879 (Year)

8. AGE:

Years	Months	Days	If less than one day
66	2	29	hr. min.

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

10. Usual occupation Architect

11. Industry or business

FATHER
12. Name William P. Allred
13. Birthplace (City, town, or county) (State or foreign country) 9

MOTHER
14. Maiden name Louise Kellogg
15. Birthplace (City, town, or county) (State or foreign country) 9

16. (a) Informant Alice B. Allred
(b) Address 5330 Pershing Ave.

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12-3-45 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla Crematory

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

19. (a) DEC 4 1945 (Date received local registrar) (b) J. F. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 30 year 1945 hour 10 minute P M.

21. I hereby certify that I attended the deceased from Nov. 10, 1945, to Nov. 30, 1945 that I last saw him alive on Nov. 30, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma head of pancreas

Due to Secondary anemia

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 Llewellyn Sale (M. D. or other)

Address 4500 Olive St. Date signed 12/4/45

(Licensed Embalmer's Statement on Reverse Side)

10524

10524

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 John Ogonoski

Licensed Embalmer No. 3398

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.