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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 JAN 11 1946

Registration District No. 318 Primary Registration District No. 1003

State File No. 38872
Registrar's No. 11122

**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: St. Luke's Hospital
(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 Sullivan 105
(c) City or town Harris NRO
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Bonita Mae 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 Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased April (Month) 16 (Day) 1930 (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---|---|---|---|---|
| | 15 | 8 | 3 | hr. min. |

9. Birthplace Chadron (City, town, or county) Nebraska (State or foreign country)
10. Usual occupation Student
11. Industry or business

FATHER
12. Name Everett Allen
13. Birthplace Unknown (City, town, or county) South Dakota (State or foreign country)

MOTHER
14. Maiden name Maxine Weymouth
15. Birthplace Chadron (City, town, or county) Nebraska (State or foreign country)

16. (a) Informant Mrs. Maxine Allen
(b) Address Harris, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-45 (Month) (Day) (Year)
(c) Place: burial or cremation Milan, Missouri
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) (Date received local registrar) DEC 19 1945 (b) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec. day 19
year 1945 hour 4 minute 20 A.M.
21. I hereby certify that I attended the deceased from Dec. 14, 1945, to Dec. 19, 1945
that I last saw her alive on Dec. 18, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death
Due to Suprasellar cyst
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations Suprasellar cyst
Of autopsy Suprasellar cyst

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 0
23. Signature [signature] (M. D. or other) M.D.
Address 4952 Maryland ave. Date signed 12/19/45
St Louis, Mo.

(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 Henry M. Brammer

Licensed Embalmer No. 4200

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.**