

S. No. 2  
M. 5-43  
15-17-39  
I X 36671

FILED MAR 31 1947  
318

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1003

Registrar's No. 199  
318

1. PLACE OF DEATH:

(a) County St. Louis, Mo

(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:  
City Infirmery Hospital  
(If not in hospital or institution, write street number and location)

(d) Length of stay: In hospital or institution 2-27-45 to 3-14-47  
(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  
5800 Arsenal St  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lebrilla Allen

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race Col.

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept. 20 1874  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 14  
year 1947 hour 4 minute 25 A. M.

21. I hereby certify that I attended the deceased from Feb. 27  
1945 to March 14 1947  
that I last saw her alive on March 14 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-Pneumonia Duration \_\_\_\_\_

Due to Senility

Due to 107

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

8. AGE: Years 72 Months 5 Days 24  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Thomas Spearman

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

{ 14. Maiden name Louise ?

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

16. (a) Informant City Infirmery Records

(b) Address 5800 Arsenal ST.

17. (a) Removal (b) Date thereof Mar 16, 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memphis, Tenn

18. (a) Signature of funeral director English Und. Co

(b) Address 2931 Lucas Ave

19. (a) MAR 19 1947 (b) J. F. Bredeek  
(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 \_\_\_\_\_

Signature Palmer Duane Bowdich (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

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**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 *Burleson English*.....

Licensed Embalmer No. *4208*.....

P. O. Address *2931 Lucas, Ave*.....

**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.**

Registration District No. 318

Primary Registration District No. 1003

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

**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:  
(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)

**3. (a) PRINT FULL NAME** Lebilia Allen

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex F

5. Color or race B

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

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

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

7. Birth date of deceased Sept 20  
(Month) (Day) (Year)

**8. AGE:** Years 72 Months 5 Days 2 If less than one day hr. min.

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

10. Usual occupation housework

**MOTHER FATHER**

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....  
(b) Address.....

17. (a) (Burial, cremation, or removal)..... (b) Date thereof.....  
(Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....  
(b) Address.....

19. (a)..... (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State..... (b) County.....

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

(d) Street No.....  
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month April year 1947 hour..... minute..... M.

21. I hereby certify that I attended the deceased from.....  
that I last saw him..... alive on..... 19.....  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy.....

**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).....

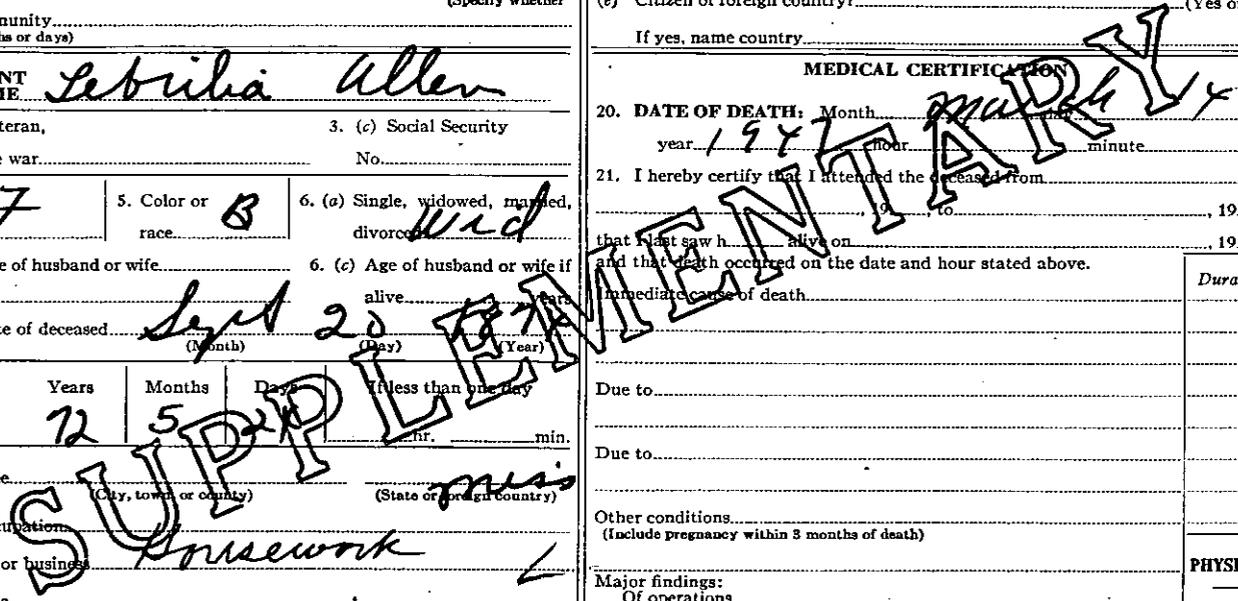
(b) Date of occurrence.....

(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..... (M. D. or other).....  
Address..... Date signed.....



APR 30 1947

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