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5-17.39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11880
Registrar's No. 822

FILED APR 14 1947

Registration District No. 317

Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Manchester
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Pine Crest Homes 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3/17/47
4/2/47 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Allen, Amanda

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F. Color or race W

5. Color or race W

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

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased June 6 1866
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>7</u>	<u>25</u>	hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER {

12. Name George Ryan

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

14. Maiden name Unknown

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

16. (a) Informant Elsa Sloan

(b) Address 7366 Elm Ave.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof Apr. 5, 1947
(Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cemetery

18. (a) Signature of funeral director Jay B. Smith

(b) Address 7456 Manchester Ave.

19. (a) 4-10-47
(Date received local registrar)

(b) George J. Sharp
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town 5100 Cabanne Ave.
(If outside city or town limits, write "RURAL")

(d) Street No. St. Louis, Mo.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2, year 1947 hour 11: minute 00 P.M.

21. I hereby certify that I attended the deceased from March 19, 1947, to April 2, 1947; that I last saw her alive on April 2, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral embolism, pyelonephritis, chronic myocarditis

Due to Heart + generalized arteriosclerosis

Due to 93d

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

Major findings: Of operations _____

Of autopsy _____

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 D

Signature G. J. Merklein M.D. (M. D. number) _____

Address 3507 Piloma Date signed 4-9-47

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

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 3454

....., Registered Apprentice No.....
working under my personal supervision.

Signed David C. Gibson

Licensed Embalmer No. 3454

P. O. Address 7456 Manchester

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.