S. No. 2
M—1/47
v. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 24 1947 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

1003

State File No. 35462
9484

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

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 Missouri Pacific
(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 .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Ill. (b) County St. Clair

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

(d) Street No. 108 Duchess Lane
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME Walter Allen

3. (b) If veteran, name war No

3. (c) Social Security No. 355-01-2220

4. Sex M

5. Color or race Negro

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

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

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

7. Birth date of deceased ..... (Month) ..... (Day) 1887 (Year)

8. AGE: Years abt 60 Months c. Days ..... If less than one day ..... hr. ..... min.

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

10. Usual occupation Laborer

11. Industry or business Railroad

FATHER
12. Name John Allen
13. Birthplace ..... (City, town, or country) Miss. (State or foreign country)

MOTHER
14. Maiden name Bettsie Lockett
15. Birthplace ..... (City, town, or county) Miss. (State or foreign country)

16. (a) Informant Robert Allen
(b) Address E. St. Louis, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/11/47 (Month) (Day) (Year)
(c) Place: burial or cremation St. Clair County, Ill.

18. (a) Signature of funeral director R.M.C. Green
(b) Address 3517 Lacledes Ave.

19. (a) OCT 14 1947 (Date received local registrar) (b) J. F. Budeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 9 year 1947 hour 12 minute 15 P.M.

21. I hereby certify that I attended the deceased from Oct 8, 1947 to Oct 9, 1947 that I last saw him alive on Oct 8, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhage	hrs
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy:	

PHYSICIAN — Underline the cause of 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 Vincent Claude M.D. (M. D. or other)
Address Mo Pac Hosp Date signed 9-10-47

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

Jefferson City Printing Co. (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 Melvin E. Green

Licensed Embalmer No. 4428

P. O. Address St. Louis, Mo

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.