

No. 300
-10-47
5-17-39
I 3906

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED APR 30 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

13809
15019
3221

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(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. Lukes 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 one
(c) City or town St. Louis (If outside city or town limits, write "RURAL") 17
(d) Street No. 5855 Washington 9
(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 1948 hour 21 minute 45 AM.
21. I hereby certify that I attended the deceased from 7-24 1947 to 4-2 1948.
that I last saw him alive on 4-2 1948.
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma floor of mouth with metastasis to lymph.
Due to lymph.
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

Major findings: Carcinoma floor of mouth
Of operations _____
Of autopsy as above

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 Louis J. Hoppe (M. D. or other) _____
Address 3720 Washington Date signed 4/2/48

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

3. (a) PRINT FULL NAME Ch Charles J. Allen
(b) If veteran, name war No 3. (c) Social Security No. 486-16-1847

4. Sex Male 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 February 1895
(Month) (Day) (Year)

8. AGE: Years 53 Months 1 Days 23 If less than one day _____ hr. _____ min.

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

10. Usual occupation Cashier

11. Industry or business _____

12. Name Samuel Allen
13. Birthplace Bond Brook New Jersey
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Watts
15. Birthplace Bond Brook New Jersey
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. R. J. Curtis
(b) Address 5855 Washington Blvd.

17. (a) Burial (b) Date thereof 4-5-48
(Specify type of removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Carmel Cemetery

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

19. (a) 1948 (b) J. F. Predeck
(Date received local Registrar's certificate) (Registrar's signature)

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.....

R. W. Wilkinson

..... Licensed Embalmer No.....

3575

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.