

FILED AUG 23 1948

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No.

27468

6931

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..... **St. Louis City 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)

3. (a) PRINT FULL NAME **Harry G. Allen**3. (b) If veteran, name war..... **World War I** 3. (c) Social Security No. **Unknown**

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..... **About 1894** years
 7. Birth date of deceased.....
 (Month) (Day) (Year)

8. AGE: Years **54?** Months **?** Days **?** If less than one day hr. min.9. Birthplace..... **St. Louis** **Missouri**
(City, town, or county) (State or foreign country)10. Usual occupation..... **Laborer**

11. Industry or business.....

12. Name..... **Unknown** 713. Birthplace..... **Unknown** 7
(City, town, or county) (State or foreign country)14. Maiden name..... **Unknown** 715. Birthplace..... **Unknown** 7
(City, town, or county) (State or foreign country)16. (a) Informant..... **Theodore Allen**(b) Address..... **Peoria, Ill.**17. (a) **Burial** (b) Date thereof..... **8-9-48**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation..... **National Cemetery**18. (a) Signature of funeral director..... **Albert H. Hoppe**(b) Address..... **4700 Washington Blvd.**19. (a) **AUG 6 1948** (b) **J. F. Kiedrich**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Missouri** (b) County..... **600**
 (c) City or town..... **St. Louis** **17**
 (If outside city or town limits, write "RURAL")
 (d) Street No..... **None** **9**
 (If rural, give location) **0**
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **1**
year **1948** hour **9:31** minute **A** M.21. I hereby certify that I attended the deceased from.....
....., 19....., to....., 19.....;that I last saw h..... alive on....., 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death **Sub Dural Hemorrhage**
Caused by fractured skull
Cause and manner of same could
 Due to..... **not be determined**
 Due to..... **open verdict**

Other conditions.....
(Include pregnancy within 3 months of death)Major findings:
Of operations..... **190**Of autopsy..... **141**

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)..... **Open Verdict**(b) Date of occurrence..... **unknown**(c) Where did injury occur?..... **unknown**
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?..... **unknown**While at work..... **See above**
(Specify type of place) (Means of injury)23. Signature..... **Patrick E. Jaybird**Address..... **By Carover** Date signed..... **8/6/48**

AUG 31 1949

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.....

Frank J. O'Neil

Licensed Embalmer No.....

2675

P. O. Address.....

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.

Registration District No. 318 Primary Registration District No. 1003

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:
(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 Harry J. Allen

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced _____

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

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

8. AGE: Years 54 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (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) (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 _____ Day _____
year 1944 hour _____ minute _____ M.

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

Duration _____

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 _____

SUPPLEMENTARY

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

MOTHER FATHER

AUG 2 1944

S-27468