

FILED MAR 23 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **10112**  
**2345**  
Registrar's No. \_\_\_\_\_

#36563

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		d. STREET ADDRESS (If rural, give location) <b>#1. 25 - 221a So. Broadway</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital</b>			d. STREET ADDRESS (If rural, give location) <b>2257</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>CHARLES</b>		b. (Middle) _____		c. (Last) <b>ALLEN</b>	
4. DATE OF DEATH (Month) (Day) (Year) <b>March 9th, 1950</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b>	8. DATE OF BIRTH <b>4/24/19</b>	9. AGE (In years last birthday) <b>70</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <b>James Allen</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Armitage</b>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>City Hospital Records</b> ADDRESS <b>1515 Lafayette</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Multiple Lung Abscesses</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH _____
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>521X</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <b>2/21/50</b> to <b>3/9/50</b> , 19____, that I last saw the deceased alive on <b>3/9/50</b> , 19____, and that death occurred at <b>3:00am</b> m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <b>D. Philomely</b>			23b. ADDRESS <b>1515 Lafayette Ave.,</b>		23c. DATE SIGNED <b>3/9/50</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>3-10-50</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Peoria, Ill.</b>	
24d. LOCATION (City, town, or county) (State) _____		25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b> ADDRESS <b>4700 Washington Blvd.</b>			
DATE REC'D BY LOCAL REG. <b>MAR 10 1950</b>		REGISTRAR'S SIGNATURE _____			

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

2745

A

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed \_\_\_\_\_

*J W Bunker*

Signed.....  
Student Embalmer

Licensed Embalmer No. 2653

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.