

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9619

FILED APR 12 1952

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2985

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 2404 Belleglade	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		11. BIRTHPLACE (State or foreign country) Chipman, Ill.	
3. NAME OF DECEASED (Type or Print) Florence Allen		4. DATE OF DEATH (Month) (Day) (Year) March 27 1952	
a. (First)		b. (Middle)	
5. SEX 3 Female		6. COLOR OR RACE Colored	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH April 17, 1887	
9. AGE (In years last birthday) 64		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Chipman, Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Tsiah Vanderburg		13b. MOTHER'S MAIDEN NAME Sarah Mitchell	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Faye Jackson 2404a Belleglade	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) Hypertensive Cardiovascular Disease Undet.	
DUE TO (c) Undetermined			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		None	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? H43X			
22. I hereby certify that I attended the deceased from 3-25, 1952, to 3-27, 1952, that I last saw the deceased alive on 3-27, 1952, and that death occurred at 1:18p m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) M. D.		23b. ADDRESS 2601 N Whittier St	
23c. DATE SIGNED 3-28-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 4/4/52	
24c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery		24d. LOCATION (City, town, or county) (State) Litchfield, Ill.	
DATE REC'D BY LOCAL REG. MAR 31 1952		REGISTRAR'S SIGNATURE G. Wade Granberry 4202 Finney Ave	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

.....
working under my personal supervision.

Student Embalmer No.

Signed Melvin E. Green

Signed.....
Student Embalmer

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.