

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006852
STATE FILE NUMBER

FILED FEB 24 1959 Registration District No. Primary Registration District No. Registrar's **2** **801**

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1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>East St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Mary's Infirmary</u>		Length of stay in lb <u>2 days</u>	d. STREET ADDRESS (If outside, give location) <u>101 South 4th St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>SPEED</u> Middle <u>ALLEN</u> Last			4. DATE OF DEATH Month <u>Jan</u> Day <u>21</u> Year <u>1959</u>		
5. SEX <u>Male</u> <u>2</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1911</u>	9. AGE (In years last birthday) <u>47</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Copper Foundry</u>	11. BIRTHPLACE (City and state or country) <u>Crystal Springs, Miss</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Jennie Mae Allen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes World War II</u>		16. SOCIAL SECURITY NO. <u>334-22-3366</u>	17. INFORMANT Address <u>Jennie Mae Allen-101 So. 4th St.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic nephritis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) <u>592X</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c)					
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Oct. 29, 1958</u> to <u>Jan. 21, 1959</u> and last saw <u>him</u> alive on <u>January 21, 1959</u> Death occurred at <u>1/21/59</u> <u>3P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Wesley H. ... M.D.</u> (Degree or title)			22b. ADDRESS <u>501 Madison X Longwood, Ill</u>		22c. DATE SIGNED <u>Jan. 22, 1959</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1/26/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National</u>		23d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Marshall Fun Home-E. St. Louis, Ill</u>			25. DATE RECD. BY LOCAL REG. <u>JAN 23 '59</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

Director, coroner, etc. must use only standard instruments as shown to. All diseases in Part I must be causally related.

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Thomas M. K. K. K.*

Licensed Embalmer No. 4479

P. O. Address. East St. Louis

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.