

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-019674

STATE FILE NUMBER

AMENDED

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1526

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Ann</u>		Length of stay in 1b <u>3 Years</u>	c. CITY OR TOWN <u>St. Ann</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>10659 St. Lawrence</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>10659 St. Lawrence</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Redmond</u> Middle <u>D.</u> Last <u>Allen</u>			4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/1878</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Clara Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

13a. FATHER'S NAME <u>Samuel Allen</u>	13b. MOTHER'S MAIDEN NAME <u>Nancy Smith</u>	14. NAME OF HUSBAND OR WIFE <u>The late Maude Allen</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>
17. INFORMANT Address <u>Samuel Allen, 3518 Edmundson Rd.</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Chr. Myocarditis</u>		<u>2 yrs 7 mo</u>
DUE TO (b) <u>arterio-sclerosis</u>		<u>3 yrs</u>
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N- <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <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 Oct 10, 1958 to May 30, 1961 and last saw ^{her} him alive on May 30, 1961
 Death occurred at 10 P m on the date stated above, and to the best of my knowledge from the causes stated.

22a. SIGNATURE (Degree or title) <u>Maurice A. Niehr M.D.</u>	22b. ADDRESS <u>9385 Page Blvd St. Louis 14, Mo</u>	22c. DATE SIGNED <u>5/8/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5/31/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>
23d. LOCATION (City, town, or county) <u>Houston</u>		State <u>Mo.</u>

24. FUNERAL DIRECTOR <u>Collier Mortuary, St. Ann, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>5-31-61</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>
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DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address St. Ann M.

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.