

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

2-43
7-39
X35897

FILED JUN 9 1944

4993

Registration District No. 318

Primary Registration District No. 1003

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:
Faith 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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 009
17th
(c) City or town St. Louis MO 9th
(If outside city or town limits, write "RURAL")
(d) Street No. 3235 N. 19 Th Str
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 0

3. (a) PRINT FULL NAME Charlin Louisa McAllister

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

4. Sex Female 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 _____ years

7. Birth date of deceased May 29 Th 1944
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 1 -- If less than one day hr. _____ min. _____

9. Birthplace St. Louis
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Charles McAllister

13. Birthplace Mo
(City, town, or county) (State or foreign country)

14. Maiden name Emily McDonnell

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

16. (a) Informant Malcolm McDonnell

(b) Address 3235 N 19 Th Str

17. (a) Burial (Burial, cremation, or removal) St. Louis Date thereof May 31st
(Month) (Day) (Year)

(c) Place: burial or cremation St. Louis Mo

18. (a) Signature of funeral director Edward Koch

(b) Address 3516 1/2 N. 14 Th. St.

19. (a) MAY 31 1944 (b) J. F. Breese
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 30 year 1944 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from 5/29, 1944 to 5/30, 1944
that I last saw her alive on 5/30, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral hemorrhage Duration 1 day.

Due to _____
Due to _____
Other conditions None
(Include pregnancy within 3 months of death)

PHYSICIAN
Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____
Of autopsy Cerebral hemorrhage

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?
(Specify type of place)
While at work _____ (e) Means of injury _____

23. Signature Jos. P. Bertram (M. D. certifier)
Address 1220 N. Grand Date signed 5/31/44

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.....

Licensed Embalmer No.....

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.