

FILED JAN 20 1945

Registration District No. 218

Primary Registration District No. 1003

Registrar's No. 174

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Mary's Infirmary
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 Days (Specify whether 0)
In this community 45 Years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Saint Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4133 Delmar
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country (P)

3. (a) PRINT FULL NAME Grace McAllister

3. (b) If veteran, name war --- 3. (c) Social Security No. None

4. Sex Female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife William Mc Allister 6. (c) Age of husband or wife if alive - years

7. Birth date of deceased March 6th 1879
(Month) (Day) (Year)

8. AGE: Years 65 Months 10 Days 1 If less than one day hr. min.

9. Birthplace Brownville Tennessee
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business ---

12. Name Unavailable

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

14. Maiden name " " "

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

16. (a) Informant Emmett McKinney

(b) Address 4133 Delmar Blvd.

17. (a) Burial (b) Date thereof 1/11/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Charles J. Gates
(b) Address 4107 Finney

19. (a) JAN 8 1945 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 7th
year 1945 hour 10 minute 30A: M.

21. I hereby certify that I attended the deceased from Dec. 30th
1944 to January 7, 1945
that I last saw her alive on January 7th, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to Hypertension

Due to Unk.
Other conditions (Include pregnancy within 3 months of death) 8 2 2

Major findings: Of operations ---
Of autopsy ---

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?
While at work --- (Specify type of place) (c) Means of injury ---

23. Signature [Signature] (M. D. or other)
Address 8228 No. Jefferson Ave Date signed ---

Duration

7 days

Unk.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

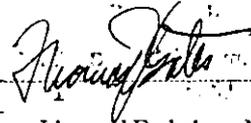
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Thomas J. Gates

.....Registered Apprentice No.

working under my personal supervision.

Signed.....



Licensed Embalmer No. **4259**

P. O. Address **4107 Finney Ave.**

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.