

FILED FEB 24 1945  
318

Registration District No. ....

Primary Registration District No. 1003

Registrar's No. 1435

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

**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:  
3643 Windsor Pl. |  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution.....  
(Specify whether  
 In this community..... 25 Years  
years, months or days)

**3. (a) PRINT FULL NAME**..... Katie Holloway

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 Widowed

6. (b) Name of husband or wife..... Charles Holloway 6. (c) Age of husband or wife if alive..... 11  
(Month) (Day) (Year)

7. Birth date of deceased.....  
(Month) (Day) (Year)

**8. AGE:** Years 58 Months 6 Days 7 If less than one day  
 hr. min.

9. Birthplace..... Macon Mississippi  
(City, town, or county) (State or foreign country)

10. Usual occupation..... House-work  
At Home

**MOTHER FATHER**

11. Industry or business.....

12. Name..... Alfred Bush

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

14. Maiden name..... Lugenia--Unknown

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

16. (a) Informant..... Edward Holloway  
 (b) Address..... 3643 Windsor Pl.

17. (a) Burial (b) Date thereof. 2-17-1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.  
Charles J. Gates  
 (e) Signature of funeral director..... 4107 Finney Ave.  
 (b) Address.....

19. (a) FEB 13 1945 (b) J. P. ...  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County.....  
 (c) City or town..... St. Louis 11  
(If outside city or town limits, write "RURAL") 000  
 (d) Street No. 3643 Windsor  
(If rural, give location) ?  
 (e) Citizen of foreign country?..... (Yes or No) 9  
 If yes, name country..... M

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month February day 12th  
 year 1945 hour 10:20 minute A.M M.

21. I hereby certify that I attended the deceased from November  
7th, 1944 to Feb. 12th, 1945  
 that I last saw h. er alive on Feb. 12th, 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Carcinoma of Uterus 2 Yrs.

Due to.....  
 Due to.....

Other conditions Nephritis 18 Mos.  
(Include pregnancy within 3 months of death)

**PHYSICIAN**

Major findings:  
 Of operations.....  
 Of autopsy.....  
 Underline the cause to which death should be charged statistically.

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)  
 Signature.....  
(M. D. or other)  
 Address..... 3136a Chouteau Date signed.....

8440

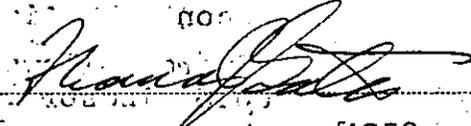
STATEMENT BY LICENSED EMBALMER

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

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.**