

**FILED** DEC 31 1945  
Registration District No. **12-1945**

Primary Registration District No. **1003**

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

17  
9

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. Anthony 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)

3. (a) PRINT FULL NAME Grace Evelyn Lightfoot

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

4. Sex Female / 5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: August 27 1971  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

74	3	5	hr. min.
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9. Birthplace Fairfax County, Virginia  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name John Williamson

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

14. Maiden name Anna E. Taylor

15. Birthplace Fairfax County Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Marguerite Nicholls

(b) Address 4170 A Cleveland

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/45  
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director: Wm. J. Robert L. & Co.

(b) Address 1905 S. Grand Blvd

19. (a) DEC 4 1945 (Date received local registrar) (b) J. F. Dussick (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 4170 A Cleveland  
(If rural, give location)

(e) Citizen of foreign country: No (Yes or No)

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 2, year 1945 hour 5 minute 53 A. M.

21. I hereby certify that I attended the deceased from November 17, 1945, to December 2, 1945; that I last saw her alive on December 2, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage Duration 1 week

Due to Arterio Sclerosis - Hypertensive 5 years

Due to Diabetes Mellitus 14 years

Other conditions: Diabetic coma 3 days

(Include pregnancy within 3 months of death)

Major findings:  
Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

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) (e) Means of injury \_\_\_\_\_

23. Signature Francis H. Wenzel (M. D. or other) M.D.

Address 5205 - Chippewa St. Date signed Dec 3 1945

**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 Ronald Yalinski

Licensed Embalmer No. 3917

P. O. Address 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 this body is not embalmed, fact should be so stated above.**