

1-1/47
17-39

FILED JAN 30 1948

Registration District No. **318** Primary Registration District No. **1003**

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: Mo. Baptist 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 Missouri (b) County.....

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

(d) Street No. 1627 Tower Grove Avenue
(If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME Grace Caldwell Hall

3. (b) If veteran, name war.....

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 21
year 1948 hour..... minute 15 P. M.

21. I hereby certify that I attended the deceased from December 15, 1947, to January 21, 1948,
that I last saw her ex alive on January 21, 1948,
and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife Wm. Antoine Hall 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased May 10 1878
(Month) (Day) (Year)

Immediate cause of death.....
Cerebral hemorrhage

Due to gen. arterio sclerosis

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>8</u>	<u>11</u>	<u>13 hr. 15 min.</u>

Due to.....

Other conditions Diabetes mellitus
(Include pregnancy within 3 months of death)

9. Birthplace Savannah Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business.....

12. Name Edwin Caldwell

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

14. Maiden name Grace Ellwood

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

Major findings:
Of operations.....

Of autopsy.....

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

16. (a) Informant Dr. Lee Hall

(b) Address 6629 Clayton Rd., St. Louis 17,

17. (a) burial (b) Date thereof 1/24/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address 6633 Clayton Rd., St. Louis 17,

19. (a) JAN 23 1948 (b) J. F. Buednick
(Date received local registrar) (Registrar's signature)

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 John L. Horner (M. D. or other) M.D.
Address 1114 W. Taylor Avenue. Date signed 1-22-48

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

MOTHER FATHER

o-o-d
17
9
8

Duration

1 mo

5-11-45

J. R. S

PHYSICIAN

Underline the cause of which death should be charged statistically.

0

M.D.

1-22-48

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 Arnold W. Schoene

Licensed Embalmer No. 3864

P. O. Address St Louis, Mo

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.

Registration District No. *318*

Primary Registration District No. *1003*

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:
(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 C. Hall*

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

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *wid*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased *may 10 1904*
(Month) (Day) (Year)

8. AGE: Years *69* Months *3* Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) *Mo*

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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 _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *1-23-48* (b) *J. F. Bredek*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year *1948* Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____; that I last saw him _____ alive on _____, 19____ and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions _____ (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) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

FEB 26 1948

S-2578-1948