

FILED FEB 1 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **988**

BIRTH NO. _____ REG. DIST. NO. **120** PRIMARY REG. DIST. NO. **4198** Registrar's No. **14**

0380
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Gentry		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Gentry	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN King City		c. LENGTH OF STAY (in the place) all life	
d. FULL NAME OF HOSPITAL OR INSTITUTION Dr. Blacklocks office		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN King City	
		d. STREET ADDRESS (If rural, give location) 0	

3. NAME OF DECEASED (Type or Print)	a. (First) Stephen	b. (Middle) Brague	c. (Last) McAllister	4. DATE OF DEATH (Month) (Day) (Year) 1.13.1953
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 11.26.1876	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Days 1	IF UNDER 24 HRS. Hours 17	Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mail Carrier.	10b. KIND OF BUSINESS OR INDUSTRY Same	11. BIRTHPLACE (State or foreign country) Gentry Co. Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME David McAllister	13b. MOTHER'S MAIDEN NAME Ellen Birbick	14. NAME OF HUSBAND OR WIFE Minnie F. McAllister
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Minnie F. McAllister. ADDRESS King City Mo.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Sclerosis DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4201			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **1-12**, 19**53**, to **Jan. 13.**, 19**53**, that I last saw the deceased alive on **Jan. 12.**, 19**53**, and that death occurred at **A** m., from the causes and on the date stated above.

23a. SIGNATURE D. B. Blacklocks, M. D. (Degree or title)	23b. ADDRESS King City Mo.	23c. DATE SIGNED 1.13.1953
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 1.14.1953	24c. NAME OF CEMETERY OR CREMATORY King City	24d. LOCATION (City, town, or county) (State) King City Mo.
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DATE REC'D BY LOCAL REG. 1-26-53	REGISTRAR'S SIGNATURE Maudie Williams 462	25. FUNERAL DIRECTOR'S SIGNATURE R. H. Yaggar ADDRESS King City Mo.
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FEB 16 1954

FEB 11 1954

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *R. G. Taggart*

Licensed Embalmer No. 2563

P. O. Address King City 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.