

FILED JAN - 5 1943

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10691**

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17
9

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:
5825 Cates Avenue
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... (Specify whether
In this community **42 yrs**
years, months or days)

3. (a) PRINT FULL NAME **JEANIE BASS ALLISON**

3. (b) If veteran, name war **NO**

3. (c) Social Security No.

4. Sex **Female**

5. Color or race **White**

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

6. (b) Name of husband or wife **James E.**

6. (c) Age of husband or wife if alive **Dec.** years

7. Birth date of deceased **11 24 1871**
(Month) (Day) (Year)

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

71 0 26 hr. min.

9. Birthplace **Nashville Tenn.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

MOTHER FATHER

12. Name **John M. Bass**

13. Birthplace **Nashville Tenn**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Berry**

15. Birthplace **Nashville Tenn**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. John A. Foster**

(b) Address **5825 Cates Ave**

17. (a) **Burial** (b) Date thereof **12-20-1942**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Bellefontaine**

18. (a) Signature of funeral director **Alexander H. Jones**

(b) Address **617.5 Delmar Blvd**

19. (a) **DEC 22 1942** (b) **J. S. Anderson**
(Date received local registrar) (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. **5825 Cates Avenue**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **December** day **20**
year **1942** hour **4** minute **20** A.M.

21. I hereby certify that I attended the deceased from **Jan.**
9, 19**35** to **Dec. 20**, 19**42**
that I last saw her alive on **Dec. 19**, 19**42**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage**

Due to **gen. arteriosclerosis & hypertension**

Due to **8 yrs.**

Other conditions **8 yrs.**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **8 yrs.**
Of autopsy **8 yrs.**

Duration

4 days

8 yrs.

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 **Samuel B. Grant** (M. D. or other) **M.D.**

Address **114 N. Taylor** Date signed **12-21-42**

Dr. Samuel Grant
114 N. Taylor J 8600

APR 26 1948

MAY 12 1948

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

John E. McCulloch

Licensed Embalmer No. *2460*

P. O. Address

6175 Pellmar

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.