. S. No. 2
DM—8-43
v. 5-17-39
I X37623

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25374

FILED AUG 24 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7114

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jewish Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Day (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 000 12
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 1232 N. Kingshighway 9
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME May 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 Widowed
6. (b) Name of husband or wife Guy
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May 18th, 1882 (Month) (Day) (Year)

8. AGE: Years 63 Months 2 Days 23 If less than one day hr. min.

9. Birthplace Paris, Tenn. (City, town, or county) 1 (State or foreign country)
10. Usual occupation Shoe-Worker
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name "
15. Birthplace " (City, town, or county) 9 (State or foreign country)

16. (a) Informant Theycel G. Allison
(b) Address 4526 Beacon Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/45 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cem.
18. (a) Signature of funeral director Kraeger-Voss
(b) Address 3402 N. Kingshighway
19. (a) AUG 13 1945 (Date received local registrar) (b) J. F. Bruecken (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 11th year 1945 hour 12 minute 5 P.M.
21. I hereby certify that I attended the deceased from 1-3-44, 19..., to 8-11-, 1945 that I last saw h. alive on 8-11, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Infarction — Duration 12 hrs.
Due to Hypertensive Cardio-Vascular disease — 2 yrs.
Due to
Other conditions (Include pregnancy within 3 months of death) 93
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) none
(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 0
23. Signature A. J. Steiner (M. D. or other) MD
Address 634 N. Grand Date signed 8/13/45

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.