

FILED FEB 24 1945

Registration District No. 377

Primary Registration District No. 3666

Registrar's No. 464

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town Kirkwood
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
U.S. Marine Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 414 days
 In this community unknown
 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kentucky (b) County unknown
 (c) City or town Paducah
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1407 So. 9th St.
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Robert McElrath

3. (b) If veteran, name war (unknown)
 3. (c) Social Security No. 402-10-5262

4. Sex Male Color or race White
 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Lora Bell McElrath
 6. (c) Age of husband or wife if alive X 40 years
 7. Birth date of deceased July 19 1900
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>44</u>	<u>4</u>	<u>11</u>		hr. _____ min.

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

10. Usual occupation Deckhand

11. Industry or business M/V Richard Moyle

12. Name William McElrath

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

14. Maiden name Laura Anderson

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

16. (a) Informant Clinical Records of hospital

(b) Address U.S. Marine Hosp., Kirkwood, Mo.

17. (a) Removal (b) Date thereof 2/15/45
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Paducah, Ky.

18. (a) Signature of funeral director _____

(b) Address 2117 E. Grand Blvd.

19. (a) FEB 16 1945 (b) E. G. Ryan
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 14
 year 1945 hour 11:40 minute P. M.

21. I hereby certify that I attended the deceased from Dec. 27, 1943
 _____, 19____, to Feb. 17, 1945, 19____

that I last saw him alive on Feb. 17, 1945, 19____
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis, far advanced 18 mo.

Due to _____

Due to _____

Other conditions _____
 (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) X

(b) Date of occurrence X

(c) Where did injury occur? X
 (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 X

23. Signature E. G. Ryan (M.D. or other)

Address U.S. Marine Hospital, Kirkwood, Mo. signed 2/14/45

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

Sr. Surgeon, Med. Off. in Charge

MAR 27 1938

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.....
Frank C. Moore

Licensed Embalmer No..... 3041

P. O. Address..... 2117 Towhead

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.