

No. 2  
43  
17-39  
X35697

1948 STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED **318**

Primary Registration District No. \_\_\_\_\_

Registrar's No. **8705**

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  
5078 Kensington Ave  
(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 MO (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 5078 Kensington Ave  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John F. McElroy

3. (b) If veteran name war \_\_\_\_\_ 3. (c) Social Security 488-01-2864

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

6. (b) Name of husband or wife Maril 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased July 14 1902  
(Month) (Day) (Year)

AGE:	Years	Months	Days	If less than one day
	<u>44</u>	<u>7</u>	<u>24</u>	hr. _____ min. _____

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Chauffeur

11. Industry or business \_\_\_\_\_

12. Name John S. McElroy

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

14. Maiden name Clara Mueller

15. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Singleton M. Elroy

(b) Address 5243 Brancroft

17. (a) Burial (b) Date thereof Oct 10-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cem.

18. (a) Signature of funeral director Robert A. Hall

(b) Address 1500 S. Brentwood

19. (a) OCT 10 1948 (b) J. F. Breeseck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day eighth  
 year 1946 hour 4 minute 15 P. M.

21. I hereby certify that I attended the deceased from JUNE 11 1946 to OCTOBER 8 1946  
 that I last saw him alive on OCTOBER 7 1946  
 and that death occurred on the date and hour stated above.

Immediate cause of death ACUTE MYOCARDITIS Duration 1 DAY

Due to CIRRHOSIS OF LIVER WITH ASCITES 2 MOS

Due to \_\_\_\_\_

Other conditions NONE  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations NONE

Of autopsy NONE

Duration

1 DAY

2 MOS

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? ( )

(e) While at work? \_\_\_\_\_ (Specify type of place) (f) Means of injury \_\_\_\_\_

23. Signature Robert A Hall (M. D. or other) MD

Address 43 WASHINGTON TERRACE Date signed 10-9-46

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

8205

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**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 Peter B. Dubrouillet

Licensed Embalmer No. 3691

P. O. Address Richmond, Va

**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.....

(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 John F McElroy

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

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

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

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 44 Months 2 Days 2 (if less than one day) hr. min.

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

10. Usual occupation chauffeur

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) (Place: burial or cremation)

18. (a) Signature of funeral director..... (b) Address.....

19. (a)..... (b) J. F. Bredeck  
(Date received local registrar) (Registrar's signature) 1946

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 July year 1946 hour..... minute..... M.

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

Immediate cause of death.....

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

MOTHER FATHER

NOV 7

35368