

FILED SEP 6 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27934

1003

State File No.

BIRTH NO. 7090.3-55 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6921

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis 13, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis,	
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital		d. STREET ADDRESS (If rural, give location) 19 4138 Maryland	
3. NAME OF DECEASED (Type or Print) a. (First) Gracia b. (Middle) Rae c. (Last) McElroy			4. DATE OF DEATH (Month) (Day) (Year) August 6 1955
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant	8. DATE OF BIRTH August 6, 1955
9. AGE (In years last birthday)		10. UNDER 1 YEAR Months	11. UNDER 1 HR. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Paul Rae McElroy	
13b. MOTHER'S MAIDEN NAME La Gracia Ann Beeler		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No.		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Paul McElroy
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atelectasis of the lungs. INTERVAL BETWEEN ONSET AND DEATH 4 hrs. ANTECEDENT CAUSES DUE TO (b) Absence lit. diaphragm DUE TO (c) Prematurity II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 76.5	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9-6 1955 , to _____, 19____, that I last saw the deceased alive on 8-6 , 19 55 , and that death occurred at 7 A m., from the causes and on the date stated above.			
23a. SIGNATURE Dr. E. Bougaly		23b. ADDRESS De Paul Hosp. - St. Louis	
23c. DATE SIGNED 8-6-55		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 8-8-55		24c. NAME OF CEMETERY OR CREMATORY Memorial Pk. Cemetery St. Louis, Mo.	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	
DATE REC'D BY LOCAL REG. AUG 8 1955		ADDRESS 4700 Washington.	

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

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 _____

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.