

FILED DEC 2 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38291**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10057**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital		e. STREET ADDRESS (If rural, give location) 19 4243 Maryland Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Nell	b. (Middle) E.	c. (Last) Grogan	4. DATE OF DEATH (Month) (Day) (Year) Nov. 16, 1955
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5. SEX F.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S.	8. DATE OF BIRTH Nov. 27, 1880	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months 11 Days 19	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Secy. Trust Dept. Mercantile Trust Co.,	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Michael Grogan	13b. MOTHER'S MAIDEN NAME Ellen Sheehan	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mr. Emmet D. Grogan	ADDRESS 5121 So. Kingshighway Blvd
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH
	2. ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) Art. Scl. Heart Disease rise to the above cause (a) stating the underlying cause last.		
	3. 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 420.0	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **11-2-1955**, to **11-16, 1955**, that I last saw the deceased alive on **11-16, 1955**, and that death occurred at **5:30** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Robert J. Farrell M.D.	23b. ADDRESS 624 N. Union	23c. DATE SIGNED 11/17/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 19, 1955	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL REG. NOV 18 1955	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE William J. Donnelly	ADDRESS 3840 Lindell Blvd.
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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 me....., Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed W. J. Saylor.....

Licensed Embalmer No. 4629

P. O. Address 3840

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.