

FILED MAY 3 1945 818

Registration District No. _____ Primary Registration District No. 1003

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: DE PAUL - HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 24 DAYS.
(Specify whether
In this community LIFE years, months or days)

3. (a) PRINT FULL NAME NICHOLAS DAVID GAILUS.

3. (b) If veteran, name war NO 3. (c) Social Security No. NONE.

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced CHILD.

6. (b) Name of husband or wife NONE 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased MARCH 27TH 1945.
(Month) (Day) (Year)

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

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

10. Usual occupation CHILD.

11. Industry or business NONE

12. Name JAMES - GAILUS, SR.

13. Birthplace ST. LOUIS - MO.
(City, town, or county) (State or foreign country)

14. Maiden name MARIE MARGRAFF.
(City, town, or county) (State or foreign country)

15. Birthplace ST. LOUIS - MO.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature James J. Gailus

(b) Address 1875 Madison St. St. Louis, Mo.

17. (a) BURIAL (b) Date thereof APRIL 21 - 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY - CEMETERY.

18. (a) Signature of funeral director Brookland Und. Co.

(b) Address 1827 Hagan St. - St. Louis, Mo.

19. (a) APR 21 1945 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 066
(c) City or town ST. LOUIS 17
(If outside city or town limits, write "RURAL")
(d) Street No. 1811 A. NO. 18th STREET.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? NO years 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 20TH
year 1945. hour 12 minute 40 P. M.

21. I hereby certify that I attended the deceased from March 28th
1945, to April 20 1945;
that I last saw her alive on April 20
and that death occurred on the date and hour stated above.

Immediate cause of death Renal failure
due to acute myocarditis
Due to the above
Due to _____

Duration 24 hrs

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 93A

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) _____
(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 J. F. Bredek (M. D. or other) 4/20/45

Address 1875 Madison Date signed 4/20/45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.

No. Embalming
Signed *John B. Brockland*
Brockland and Co
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, above space should be left blank.