V. S. No. 2
0M—1/47
ev. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39963

FILED DEC 15 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10922

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: St. Louis Childrens Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 hours (Specify whether
In this community LIFE
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

(c) City or town St Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. RT #1 Bx. 575 (Florrisant) 9
(If rural, give location)
N.R.

(e) Citizen of foreign country? (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Renee Robin Menard

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

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

7. Birth date of deceased November 10 1947
(Month) (Day) (Year)

8. AGE: Years | Months | Days 16 | If less than one day hr. min.

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

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Glenn Menard
13. Birthplace St Louis MO
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Delores Bone
15. Birthplace St. Louis, MO
(City, town, or county) (State or foreign country)

16. (a) Informant Glenn Menard
(b) Address RR #1 Bx 575 Florrisant, Mo

17. (a) Burial (b) Date thereof 11-28-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine Cem.

18. (a) Signature of funeral director A W McLaughlin
(b) Address 3301 Lafayette

19. (a) NOV 29 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 26
year 47 hour 12 minute 50 AM.

21. I hereby certify that I attended the deceased from 11-25, 1947, to 11-26, 1947;
that I last saw her alive on 11-26, 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death acidosis, dehydration & anhydremia, resp. collapse	
Due to vomiting & diarrhea	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause of 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? (Specify type of place)

While at work? (e) Means of injury 0

Signature Gilbert B. Forbes (M. D. or other)

Address ST. LOUIS CHILDRENS, Hosp. Date signed 11-[illegible]-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 C W Cooper

Licensed Embalmer No. 8830

P. O. Address 2301 Lafayette

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.