

STANDARD CERTIFICATE OF DEATH

BIRTH NO. 4459-51 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Johns Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>822 No 10th Street</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Victor</u> b. (Middle) <u>Harvey</u> c. (Last) <u>LaMonte</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 11 1951</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept 17, 1951</u>	9. AGE (In years last birthday) <u>25</u>	IF UNDER 1 YEAR Months <u>25</u>	IF UNDER 24 HRS. Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>****</u>	11. BIRTHPLACE (State or foreign country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Robert F. LaMonte</u>	13b. MOTHER'S MAIDEN NAME <u>Marie Natoli</u>	14. NAME OF HUSBAND OR WIFE <u>*****</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Robert F. LaMonte</u> ADDRESS <u>822 No. 10th St</u>
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonitis - Bilateral</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Aspiration - Formula.</u> DUE TO (c) <u>Megacystophagus - distal third</u> <u>Enter auricular Septal Defect.</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? <u>763.0</u>
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22. I hereby certify that I attended the deceased from Sept 17, 1951, to Oct 11, 1951, that I last saw the deceased alive on Oct 11, 1951, and that death occurred at 11:05 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Paul G. Felich, M.D.</u> (Degree or title)	23b. ADDRESS <u>St. Johns Hospital</u>	23c. DATE SIGNED <u>Oct 12-1951</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10-13-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Clay City</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>OCT 13 1951</u>	REGISTRAR'S SIGNATURE <u>Earl Smith</u>	FUNERAL DIRECTOR'S SIGNATURE <u>Bensiek-Niehans</u> ADDRESS <u>1431 Union Bl.</u>
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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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Frank H. McRees

Licensed Embalmer No. 2915

P. O. Address St Louis Mo

**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.