

FILED JUL 26 1954

STANDARD CERTIFICATE OF DEATH

State File No. **24949**
Registrar's No. **6529**

BIRTH NO. **48083-54** 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 Mo. b. COUNTY	
b. CITY (If outside corporate limits, write BURIAL and give town) St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place)		STREET ADDRESS 4101 Wilmington 2019	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthonys Hosp.			

3. NAME OF DECEASED (Type or Print) a. (First) Gary b. (Middle) F. c. (Last) Menendez		4. DATE OF DEATH (Month) (Day) (Year) July 16 1954	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH July 15 1954
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 48 HRS. Hours Mins. 13 130
11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? Mo.	

13a. FATHER'S NAME Frank Menendez	13b. MOTHER'S MAIDEN NAME Dorothy Getzhine	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Frank Menendez 4101 Wilmington

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, asthma, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aspiration of Ammonia Fluid		INTERVAL BETWEEN ONSET AND DEATH 13 1/2 hrs.
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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 2	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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 7625

22. I hereby certify that I attended the deceased from **July 15, 1954**, to **July 16, 1954**, that I last saw the deceased alive on **July 16, 1954**, and that death occurred at **7:20 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Walter J. Sumner	(Degree or title) 0	23b. ADDRESS 4617 Dublin Ave	23c. DATE SIGNED 7/16/54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7-17-1954	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope	24d. LOCATION (City, town, or county) (State) Lemay Mo.

DATE REC'D BY LOCAL REG. JUL 16 1954	REGISTRAR'S SIGNATURE J. Carl Smith Mo	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Jos. P. Fendler Jr. 7128 Michigan
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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 Not Embalmed, Student Embalmer No. _____ working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Clarence Pehon

Licensed Embalmer No. 309

P. O. Address 7128 Michigan

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.