

FILED FEB 1 - 1955

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2215**
Registrar's No. **62**

BIRTH NO. _____ REG. DIST. NO. **306** PRIMARY REG. DIST. NO. **6048**

1. PLACE OF DEATH a. COUNTY ST. CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY ST. CHARLES	
b. CITY (If outside corporate limits, write RURAL and give township) O'FALLON		c. CITY (If outside corporate limits, write RURAL and give township) O'FALLON	
c. LENGTH OF STAY (In this place) _____		d. STREET ADDRESS (If rural, give location) 08206	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____			

3. NAME OF DECEASED a. (First) LOUIS b. (Middle) H. c. (Last) DUMONTIER		4. DATE OF DEATH (Month) (Day) (Year) JAN. 16 1955	
5. SEX M	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH APRIL 4 - 1885
9. AGE (In years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC	11. BIRTHPLACE (State or foreign country) DETROIT MICH. 1
10b. KIND OF BUSINESS OR INDUSTRY _____		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME DUMONTIER	13b. MOTHER'S MAIDEN NAME DEVINE	14. NAME OF HUSBAND OR WIFE MRS. MARY DUMONTIER
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. 575295808	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Mrs. Louise DuMontier O'Fallon Mo

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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 min
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Atherosclerosis DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized Atherosclerosis			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4201		20. AUTOPSY? YES <input 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) O'Fallon Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Jan 1, 1949**, to **Jan 16, 1955**, that I last saw the deceased alive on **16 Jan, 1955**, and that death occurred at **2:30 A. M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Louis Dumontier M.D.	23b. ADDRESS O'Fallon Mo	23c. DATE SIGNED 21 Jan 55
24a. BURIAL CREMATION, REMOVAL (Specify)	24b. DATE JAN. 18 - 55	24c. NAME OF CEMETERY OR CREMATORY Assumption
24d. LOCATION (City, town, or county) (State) O'Fallon Mo		

DATE REC'D BY LOCAL REG. Jan 22 55	REGISTRAR'S SIGNATURE E. A. Keithley	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS E. A. Keithley O'Fallon Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1953

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

E. Keithy

Signed.....
Student Embalmer

Licensed Embalmer No. *822*

P. O. Address *Fallon 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.