

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24822

State File No. \_\_\_\_\_

FILED AUG 10 1955

BIRTH NO. 60798-55 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 590 Registrar's No. 1162

1. PLACE OF DEATH a. COUNTY <u>Berkley Mo.</u> St. Louis. Co. b. CITY (If outside corporate limits, write RURAL and give town or township) <u>Berkley</u> c. LENGTH OF STAY (In this place) <u>7 days</u> d. FULL NAME OF (If not in hospital or institution, give street address or location) <u>5965 Stoneham</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis, Mo.</u> c. CITY OR TOWN <u>Berkley</u> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> e. STREET ADDRESS (If rural, give location) <u>5965 Stoneham</u>	
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3. NAME OF DECEASED (Type or Print) a. (First) <u>Susan Jane Renaud</u> b. (Middle) c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <u>July 30, 1955</u>
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5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 14, 1955</u>	9. AGE (In years last birthday) <u>16</u> If UNDER 1 YEAR: Months _____ Days _____ If UNDER 4 HRS: Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Walter Renaud</u>	13b. MOTHER'S MAIDEN NAME <u>Juniata Howell</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (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>Walter Renaud</u>	ADDRESS <u>5965 Stoneham Berkley</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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>unk</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>unknown natural causes</u>		
	II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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?
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <u>Herbert R. Domke</u> (Degree or title) <u>Local Registrar</u>	23b. ADDRESS <u>651 S. Brentwood Blvd.</u>	23c. DATE SIGNED <u>8-9-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Aug. 2, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's</u>	24d. LOCATION (City, town, or county) (State) <u>Kirkwood Mo.</u>
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DATE REC'D BY LOCAL REG. <u>8/1/55</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Domke M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Quinn</u>	ADDRESS <u>1339 Union Blv</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

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**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.....  
Signature of Student Embalmer

Signed.....

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 embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.

If this body is not embalmed, fact should be so stated above.