

FILED DEC 2 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38523**
Registrar's No. **10064**

BIRTH NO. _____ 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 Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (in this place) 5 yrs.	c. CITY OR TOWN St. Louis	d. Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Christian Hospital			
e. STREET ADDRESS 26		f. (If rural, give location) 1830 No. 18th St. 226 1/2	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) John	b. (Middle) _____	c. (Last) LeGrand	Nov.	16	1955

5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 31, 1905	9. AGE (In years last birthday) 50	if UNDER 1 YEAR Months 3	if UNDER 12 HRS. Days 16	if UNDER 1 MIN. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tinner		10b. KIND OF BUSINESS OR INDUSTRY Automotive		11. BIRTHPLACE (City and State or Foreign Country) Delta, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME August Le Grand		13b. MOTHER'S MAIDEN NAME Millie Cox		14. NAME OF HUSBAND OR WIFE Violet Le Grand			
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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)		16. SOCIAL SECURITY NO. 702-09-5439		17. INFORMANT'S SIGNATURE OR NAME Violet Le Grand ADDRESS 1830 No. 18th St.			
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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, atherosclerosis, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH 3 hrs
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation	ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Rheumatic Heart Disease DUE TO (c) Atherosclerotic Ulcer						Undetermined
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none							Undetermined

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4/6 x				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) St. Louis		(COUNTY) Missouri		(STATE) _____	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
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22. I hereby certify that I attended the deceased from Oct 25, 1955, to Nov. 16, 1955, that I last saw the deceased alive on Nov. 16, 1955, and that death occurred at 5:12 P. M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Anthony J. Vitale M.D.			23b. ADDRESS 3861 St. Louis Ave			23c. DATE SIGNED 11/18/55		
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Nov. 19, 1955		24c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cemetery		24d. LOCATION (City, town, or county) St. Louis County		(State) _____	
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DATE REC'D BY LOCAL REG. Nov 18 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.			25. FUNERAL DIRECTOR'S SIGNATURE Beiderwieden F. H. Inc. ADDRESS 1936 St. Louis Ave				
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(Licensed Embalmer's Statement on Reverse Side)

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

*Dr. W. Vitale,
3861 St. Louis Ave.*

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 None
Signature of Student Embalmer

Signed Delia J. Krupar

Licensed Embalmer No. 34

P. O. Address St. Louis

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.