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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 2899

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 718

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N.Grand,St.Louis,Mo. Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Vet.Adm.Hospital Length of stay in 1b 23 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY JEFFERSON
c. CITY OR TOWN HOUSE SPRINGS 0500 Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) ROUTE NO. 2 Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First LEO Middle H. Last LA BRUYERE
4. DATE OF DEATH Month 1 Day 22 Year 57

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 8-28-1900
9. AGE (In years last birthday) 56 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPEFITTER
10b. KIND OF BUSINESS OR INDUSTRY Dow Chemical Co.
11. BIRTHPLACE (City and state or country) BONNE TERRE, MISSOURI
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William LaBruyere
14. MOTHER'S MAIDEN NAME MINNIE PALMER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW-I
16. SOCIAL SECURITY NO. 710-18-4129
17. INFORMANT VA HOSP.RECORDS,915 N.GRAND, ST.LOUIS,MO. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG WITH CEREBRAL METASTASES — INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 163.x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. VA I attended the deceased from 12-30-56 to 1-22-57 and last saw him alive on 1-22-57
Death occurred at 1:20 PM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Murray M. Bert (Degree or title) M.D.
22b. ADDRESS 915 N.Grand VA Hosp. St.Louis, Mo.
22c. DATE SIGNED 1-22-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE Jan.25,1957
23c. NAME OF CEMETERY OR CREMATORY National Cemetery
23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.

24. FUNERAL DIRECTOR Kriegshauser ADDRESS 4228 S.Kingshighway
25. DATE RECD. BY LOCAL REG. JAN 23 57
26. REGISTRAR'S SIGNATURE Carl Smith MD M&B

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was en

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 45

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.