

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 27 1957

State File No. 10723

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2353

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 RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (In this place) _____
c. CITY OR TOWN St. Louis d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION 01 2711a Dodier St. e. STREET ADDRESS (If rural, give location) 2 209 2711a Dodier St.

3. NAME OF DECEASED a. (First) Sophia b. (Middle) _____ c. (Last) Menard 4. DATE OF DEATH (Month) (Day) (Year) 3 6 57

5. SEX F / W 6. COLOR OR RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 8. DATE OF BIRTH June 15th 1863 9. AGE (In years last birthday) 93 IF UNDER 1 YEAR Months Days IF UNDER 6 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY ----- 11. BIRTHPLACE (City and State or Foreign Country) Canada 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Joseph Boyer! 13b. MOTHER'S MAIDEN NAME Judith (Unknown) 14. NAME OF HUSBAND OR WIFE Josen h Menard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Nellie Coffrey 2711a Dodier St.

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. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ARTERIOSCLEROTIC HEART DISEASE ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ARTERIOSCLEROSIS, GENERALIZED 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 _____ 20. AUTOPSY? 420.0 YES NO

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) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from JAN 20, 1955 to MARCH 6, 1957, that I last saw the deceased alive on MARCH 4, 1957, and that death occurred at 7:30 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Carl W. Lammie, M.D. 23b. ADDRESS 3731 GOODFELLOW BLVD. 23c. DATE SIGNED 3/7/57

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 3/9/57 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery 24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. MAR 8 '57 REGISTRAR'S SIGNATURE [Signature] 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert D. Kinealy 2228 St. Louis Ave.

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

3731 Goodfellow
Dr. Tenier

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 *James W. Harty*.....

Licensed Embalmer No. *3882*.....

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.