

FILED APR 8 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHSTATE FILE NUMBER  
11488

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 254

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St. Louis</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>                |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Kirkwood</b>  |                                  | c. CITY OR TOWN <b>Kirkwood</b> 4683  |   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph's Hos.</b>  |                                  | Length of stay in lb <b>60yrs.</b>  |   |
| d. STREET ADDRESS <b>551 N. Harrison</b>  |                                  | Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Martin</b> Middle <b>M.</b> Last <b>La Lumandiere</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>March</b> Day <b>20</b> Year <b>1957</b>   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 12, 1890</b>                                |
| 9. AGE (In years (not birthday))<br><b>66</b>   |                                  | IF UNDER 1 YEAR<br>Months _____ Days _____  | IF UNDER 24 HRS.<br>Hours _____ Min. _____                              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Custodian (Retired)</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Osage Theatre</b>   | 11. BIRTHPLACE (City and state or country)<br><b>St. Genevieve, Mo.</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                                  | 13. FATHER'S NAME<br><b>Lucian La Lumandiere</b>  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>   |   |
| 16. SOCIAL SECURITY NO.<br><b>488-12-9816</b>   |                                  | 17. INFORMANT<br><b>Rosemary La Lumandiere, 551 N. Harrison</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>acute Viral Hepatitis</b><br>DUE TO (b) <b>unknown</b><br>DUE TO (c) <b>unknown</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)<br><b>Admission to Hospital</b> |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 days!</b>                      |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |   |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                  |   |   |
| 20c. TIME OF INJURY - Hour _____ Month _____ Day _____ Year _____<br>a. m. _____ p. m. _____  |                                  |   |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                  | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |   |
| 20f. CITY, TOWN, OR LOCATION  |                                  | COUNTY STATE  |   |
| 21. I attended the deceased from <b>Dec. 1916</b> to <b>3-20-57</b> and last saw <sup>her</sup> him alive on <b>9-20-57</b><br>Death occurred at <b>2:30</b> a. m. on the date stated above; and to the best of my knowledge, from the causes stated.   |                                  |   |   |
| 22a. SIGNATURE (Degree or title)<br><b>J. H. Barnett, M.D.</b>  |                                  | 22b. ADDRESS<br><b>9929 Jambouille<br/>Kirkwood, LL, MO</b>   |   |
| 22c. DATE SIGNED<br><b>3-20-57</b>  |                                  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |   |
| 23b. DATE<br><b>3/22/57</b>   |                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Peter's Cemetery</b>   |   |
| 23d. LOCATION (City, town, or county) (State)<br><b>Kirkwood 22, Mo.</b>  |                                  | 24. FUNERAL DIRECTOR<br><b>Pfitzinger Mortuary, Kirkwood, Mo.</b>   |   |
| 25. DATE RECD. BY LOCAL REG.<br><b>3/21/57</b>  |                                  | 26. REGISTRAR'S SIGNATURE<br><b>Herbert B. Dombek</b>   |   |

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Services

300  
1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Securing the medical certificate in this manner is essential.

**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 *[Handwritten Signature]*.....

Licensed Embalmer No. *436*

P. O. Address *[Handwritten 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.