

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14927

STATE FILE NUMBER

FILED APR 26 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar's **3545**

Health, & Welfare
Public Service

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 casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | | | | | | |
|--|----------------------------------|---|--|---|--|--|---|--|
| 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, give TOWNSHIP only) OR TOWN ST. LOUIS | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1 | | | d. STREET ADDRESS (If outside, give location) 1409 S. 7th | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First ERNEST Middle WILLIAM Last IAA. BRUYERE | | | | 4. DATE OF DEATH APRIL 11, 1957 Month Day Year | | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH 4-12-1888 | | 9. AGE (In years last birthday) 68 | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager, Kroger | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (City and state or country) Desloge, Missouri | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME Jule LaBruyere | | | | 14. MOTHER'S MAIDEN NAME Adaline Beckett | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 488-18-7985A | | 17. INFORMANT Address Frank LaBruyere, High Ridge, Mo. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock following laparotomy Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Esophagojejunal anastomosis & strangulation of bowel 7 days post-operatively - DUE TO (c) Carcinoma of the stomach and esophagus - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e.g.,) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 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.) 15M | | | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year 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 3/25/57 to APRIL 11, 1957 and last saw her alive on APRIL 11, 1957 Death occurred at 10:30 P m on the date stated above; and to the best of my knowledge, from the causes stated? | | | | | | | | |
| 22a. SIGNATURE (Degree or title) Richard J. Remme, M.D. | | | | 22b. ADDRESS 1315 LAFAYETTE AVE. | | 22c. DATE SIGNED 4/12/57 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 4-15-57 | 23c. NAME OF CEMETERY OR CREMATORY New St. Marcus | | 23d. LOCATION (City, town, or county) (State) -St. Louis Co., Missouri | | | |
| 24. FUNERAL DIRECTOR ADDRESS McLAUGHLIN'S, 2301 Lafayette | | | 25. DATE RECD. BY LOCAL REG. APR 15 '57 | | 26. REGISTRAR'S SIGNATURE J. Carl Smith MD | | | |

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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

L. R. Coase

Licensed Embalmer No. *363*

P. O. Address *237 R*

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.