

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15720**
Registrar's No. **908**

FILED APR 29 1957

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500**

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

1. PLACE OF DEATH a. COUNTY Lamay St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY OR TOWN Lamay		c. CITY OR TOWN Lamay	
c. LENGTH OF STAY (in this place) 6 Mo.		d. STREET ADDRESS (If rural, give location) 1204 Telegraph Road	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lamay Nursing Home			

3. NAME OF DECEASED (Type or Print) Adelard Chevalier	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) 4 (Day) 6 (Year) 57
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 15, 1868	9. AGE (in years last birthday) 88	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Leather Worker	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Canada	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Delia Stanton Chevalier
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	(If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. 489-16-9320A	17. INFORMANT'S SIGNATURE OR NAME Jimmy Benson	ADDRESS 7803 Weaver Av.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Apoplexy ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 2 min 12 yrs.
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? 2 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) (COUNTY) (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 type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **1/4**, 19**57**, to **3/6**, 19**57**, that I last saw the deceased alive on **3/6**, 19**57**, and that death occurred at **8:30 A** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Michael J. Barusch SM 10	23b. ADDRESS 7615 So Broad way	23c. DATE SIGNED 3/6/57
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 4/9/57	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
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DATE REC'D BY LOCAL REG. 4-8-57	REGISTRAR'S SIGNATURE Herbert B. Donohue	25. FUNERAL DIRECTOR'S SIGNATURE L. Mullen & Sons	ADDRESS 5165 Delmar Bl.
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7615 So. Broadway
W. B. Bostwick

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
Student Embalmer

Signed *James O. Leutz* _____

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 this body is not embalmed, fact should be so stated above.