

FILED NOV 6 1957

STANDARD CERTIFICATE OF DEATH

37463

STATE FILE NUMBER

9430

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN OVERLAND	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MO BAPTIST HOSP		d. STREET ADDRESS 9612 TENNYSON	
3. NAME OF DECEASED (Type or print) First MIDDLE Last LEO - GIRARD		4. DATE OF DEATH Month Day Year 10-8-57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-20-1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TINTER		10b. KIND OF BUSINESS OR INDUSTRY PAINT	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO
13. FATHER'S NAME LOUIS GIRARD		14. MOTHER'S MAIDEN NAME CATHERINE HESTER	
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. 490-14-5418	17. INFORMANT MARY GIRARD 9612 TENNYSON
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia and bronchitis DUE TO (b) Arteriosclerotic heart disease with cardiac decompensation DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 wk
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.) 4200	
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 Oct. 1 '57 to Oct. 8 '57 and last saw him alive on Oct. 8 '57 Death occurred at 8 PM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Richard Jones MD		22b. ADDRESS 3720 Washington	
22c. DATE SIGNED Oct. 9 '57			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10-11-57	
23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		23d. LOCATION (City, town, or county) (State) ST. LOUIS, MO	
24. FUNERAL DIRECTOR ORTMANN F HOME 9222 LACKLAND OVERLAND 14, MO.		25. DATE RECD. BY LOCAL REG. OCT 9 57	
26. REGISTRAR'S SIGNATURE J. Carl Smith MD			

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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

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 *Al. C. Outmann*

Licensed Embalmer No. *347*

P. O. 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.