

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42344

State File No. ....

FILED NOV 27 1957

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11129

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 11 d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION St. Lukes Hosp. e. STREET ADDRESS (If rural, give location) 6935 Alabama Ave.

3. NAME OF DECEASED a. (First) Nicky b. (Middle) Lee c. (Last) Menendez 4. DATE OF DEATH (Month) (Day) (Year) Nov. 4-57

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Neither 8. DATE OF BIRTH Nov. 4-1957 9. AGE (In years last birthday) 1 IF UNDER 1 YEAR Months \_\_\_\_\_ Days \_\_\_\_\_ IF UNDER 24 HRS. Hours \_\_\_\_\_ Mins. 10

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

13a. FATHER'S NAME Raymon Menendez 13b. MOTHER'S MAIDEN NAME Maxine Sue Patterson 14. NAME OF HUSBAND OR WIFE \_\_\_\_\_

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) \_\_\_\_\_ 16. SOCIAL SECURITY NO. \_\_\_\_\_ 17. INFORMANT'S SIGNATURE OR NAME Mrs. Raymon Menendez ADDRESS 6935 Alabama

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
MEDICAL CERTIFICATION  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Absence of diaphragm with herniation abdominal viscera into thorax congenital  
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  
DUE TO (b) \_\_\_\_\_  
DUE TO (c) \_\_\_\_\_  
II. OTHER SIGNIFICANT CONDITIONS atalectasis bilateral ducts compression of abdominal viscera  
INTERVAL BETWEEN ONSET AND DEATH 70 min.

19a. DATE OF OPERATION \_\_\_\_\_ 19b. MAJOR FINDINGS OF OPERATION \_\_\_\_\_ 20. AUTOPSY? 759.2 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 Nov. 4, 19 57, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on Nov. 4, 19 57, and that death occurred at 6:35 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) William A. M. Goussier M.D. 23b. ADDRESS 8230 Joseph 23c. DATE SIGNED Nov. 12, 1957

24a. BURIAL, CREMATION, REMOVAL (Specify) \_\_\_\_\_ 24b. DATE 11-30-57 24c. NAME OF CEMETERY OR CREMATORY Anatomical Board 24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. NOV 21 '57 REGISTRAR'S SIGNATURE Paul Smith 25. FUNERAL DIRECTOR'S SIGNATURE Rowland - Sker ADDRESS 410 Y Manchester

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

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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.....

Licensed Embalmer No.....

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.