

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019696

STATE FILE NUMBER  
Registration District No. **4466**

FILED MAY 22 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital		Length of stay in lb D.O.A.		d. STREET ADDRESS 4552 Laclede Ave.	

3. NAME OF DECEASED (Type or print) First LOUIS			Middle P.			Last TERREBONNE			4. DATE OF DEATH Month May			Day 5			Year 1959				
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 Aug. 25, 1913			9. AGE (In years last birthday) 45			10. FUNDER 1 YEAR Months		Days		IF UNDER 24 HRS Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed-Laborer				10b. KIND OF BUSINESS OR INDUSTRY Contractor				11. BIRTHPLACE (City and state or country) New Orleans, La.				12. CITIZEN OF WHAT COUNTRY? U.S.A.							

13a. FATHER'S NAME Alidora Terrebonne			13b. MOTHER'S MAIDEN NAME Gabrielle Chighizola			14. NAME OF HUSBAND OR WIFE Ruth J. Terrebonne					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War 2			16. SOCIAL SECURITY NO. 437-10-2871			17. INFORMANT Ruth J. Terrebonne			Address 4552 Laclede Ave.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atherosclerotic Coronary Artery Disease with early Myocardial Infarction.</i>								INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c) <i>Pulmonary Edema and early</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (If any, list in full, but do not repeat those given in PART I (a)) <i>Stroke</i>		19. WAS AUTOPSY PERFORMED? 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.) 420.1						
20c. TIME OF INJURY Hour a.m. p.m.									

20d. INJURY OCCURRED WHILE AT <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 New Orleans, La.		COUNTY		STATE	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ <i>950 A</i> on the date stated above; and to the best of my knowledge, from the causes stated.									

22a. SIGNATURE <i>Patrick Taylor Crommett</i>			22b. ADDRESS 300 Clark			22c. DATE SIGNED 5.6.59.		
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Rail) 5-6-1959		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY New Orleans, La.		23d. LOCATION (City, town, or county) (State)	
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24. FUNERAL DIRECTOR Kriegshauser 4228 S.Kingshighway			25. DATE RECD. BY LOCAL REG. MAY 6 '59		26. REGISTRAR'S SIGNATURE <i>Walter Smith, M.D.</i>		
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Health, Welfare, Public Service, 00, 57, 79, 0, All diseases to Part I must be completely stated.

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 *Edwin A. Baker* .....

Licensed Embalmer No. *302* .....

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.