

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-003951

FILED VS FEB 24 1961

Registration District No. 377 Primary Registration District No. 500 Registrar's No. 279 STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF THIS RECORD TAKE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>St Louis</b>  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>St Louis</b> |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Florissant</b>  |   | Length of stay in 1b<br><b>9 months</b>   | c. CITY OR TOWN <b>Florissant</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>515 Allen St</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>515 Allen</b>   |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Agnes</b> Middle <b>K</b> Last <b>Legrand</b>   |   |   | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>28</b> Year <b>1961</b>  |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11/20/1888</b>   | 9. AGE (last birthday)<br><b>72</b>   | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/>      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Keeper</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |   | 11. BIRTHPLACE (City and state or country)<br><b>Newton Mass.</b>   | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>   |
| 13a. FATHER'S NAME<br><b>George Legrand</b>   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |   | 14. NAME OF HUSBAND OR WIFE<br><b>George P. Legrand</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   | 17. INFORMANT<br><b>Paul Legrand Florissant Mo.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b>  |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 MINUTES</b>                                  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>ATHEROSCLEROTIC &amp; HYPERTENSIVE HEART DISEASE</b>  |   |   |   |   | <b>unknown</b>  |
| DUE TO (c) _____  |   |   |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>none</b>  |   |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" 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.)  |   |   |   |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.<br>Month, Day, Year _____   |   |   |   |   |   |
| 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 <b>April 4, 1960</b> to <b>July 20, 1960</b> and last saw her <b>him</b> alive on <b>July 20, 1960</b><br>Death occurred at <b>2 am</b> on <b>1/28/1961</b> on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |   |   |
| 22a. SIGNATURE (Degree or title)<br><b>Charles Danheiser M.D.</b>   |   |   | 22b. ADDRESS<br><b>150 W. ACACAC, CHAYTON, MO.</b>  |   | 22c. DATE SIGNED<br><b>1/29/61</b>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |   | 23b. DATE<br><b>Jan. 28 1961</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St Patricks Cemetery</b>   |   | 23d. LOCATION (City, town, or county) (State)<br><b>Lowell Mass.</b>                  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Arthur C Baue Inc. St Charles Mo.</b>  |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>1-29-61</b>  |   | 26. REGISTRAR'S SIGNATURE<br><b>John Murphy M.D.</b>                                  |

**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 Arthur C. Pine

Licensed Embalmer No. 3151

P. O. Address 1700 Maple St

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.