

FILED JAN 7 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 44328

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <u>312</u>  |  | PRIMARY REG. DIST. NO. <u>590</u>  |  | Registrar's No. <u>2985</u>   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis</u>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Pine Lawn</u> )   |  | c. LENGTH OF STAY (in this place) <u>1 Month</u>   |  | c. CITY OR TOWN <u>Normandy</u>  |  | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3709 Manola</u>  |  |  |  | STREET ADDRESS (If rural, give location) <u>7105 Lexington Ave</u>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>EDWARD</u> b. (Middle) <u>MAURICE</u> c. (Last) <u>MUNIER</u>  |  |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 15, 1956</u> |  |  |   |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>  |  | 8. DATE OF BIRTH <u>Sept. 22, 1886</u>  |  |
| 9. AGE (In years last birthday) <u>70</u>   |  | IF UNDER 1 YEAR Months _____ Days _____  |  | IF UNDER 1 YEAR Hours _____ Min. _____   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Glaser</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Glass Co.</u>  |  | 11. BIRTHPLACE (City and State or Foreign Country) <u>St. Genevieve Mo.</u>  |  |   |  |
| 13a. FATHER'S NAME <u>August Munier</u>   |  | 13b. MOTHER'S MAIDEN NAME <u>Mary LaBriere</u>   |  | 14. NAME OF HUSBAND OR WIFE <u>Ida Lattrace</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>  |  | 16. SOCIAL SECURITY NO. <u>488-09-2586a</u>  |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Florence Fox 7105 Lexington</u>  |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.                               |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral thrombosis</u><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Arteriosclerotic Cardiovascular disease</u><br>DUE TO (c) <u>unknown</u><br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION <u>4221</u>   |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 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) (Min.)  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21f. HOW DID INJURY OCCUR?   |  |   |  |
| 22. I hereby certify that I attended the deceased from <u>Nov 16, 1956</u> to <u>Dec 15, 1956</u> , that I last saw the deceased alive on <u>Dec 16, 1956</u> , and that death occurred at <u>7:55 a.m.</u> , from the causes and on the date stated above. |  |  |  |  |  |   |  |
| 23a. SIGNATURE <u>Lewis Litterman</u> (Degree or title) <u>MD</u>   |  |  |  | 23b. ADDRESS <u>4231 Clayton Rd (17)</u>   |  | 23c. DATE SIGNED <u>12/17/56</u>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>  |  | 24b. DATE <u>12/18/56</u>  |  | 24c. NAME OF CEMETERY OR CREMATORY <u>Galvary Cemetery</u>   |  | 24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>  |  |
| DATE REC'D BY LOCAL REG. <u>12-17-56</u>  |  | REGISTRAR'S SIGNATURE <u>Robert B. Donohue MD</u>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Cullen Kelly</u>   |  | ADDRESS <u>7267 Natural Bridge</u>  |  |

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.....  
*James A. Lawrence*

Licensed Embalmer No. *41*  
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.