N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

41385

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. 12066

Township ..... Primary Registration District No. ..... Registered No. .....

City St Louis (No. City Hospital ..... St. ..... Ward)

2. FULL NAME 15834 Bernard J. L. Leusbrock (LEUSBROCK)

(a) Residence. No. 4822 Fruit St., 6 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 17-1887

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	43	10	7	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer Day
(b) General nature of industry, business, or establishment in which employed (or employer) Maloney Electric Co
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) St Louis
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Bernard Leusbrock
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Katherine Raiman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

14. INFORMANT Hospital Information
(Address) City Hospital

15. FILED DEC 26 1930 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 24 1930

17. I HEREBY CERTIFY, That I attended deceased from Dec 18, 1930, to Dec 24, 1930 that I last saw him alive on Dec 24, 1930 and that death occurred, on the date stated above, at 10:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Multiple Ascesses of lungs cause unknown
109 A (duration) ..... yrs. ..... mos. ..... ds.
11 HR Pneumonia not
CONTRIBUTORY (SECONDARY) Colon or Lunch #103 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Joseph T Maher, M. D.
19/24/30 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Calvary	Dec 27 1930

20. UNDERTAKER	ADDRESS
Math Hermann & Son	2161 Park

ON

Leuschner.