

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

Do not use this space.

**791
1008**

17521

File No. _____
Registered No. **4433**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. _____
Township _____ Primary Registration District No. _____
City St. Louis (No. City Hospital)

2. FULL NAME

Wilhelm Leining
(a) Residence, No. 1010 Emmett St. 23 Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar. 12 - 1884

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>78</u>	<u>1</u>	<u>22</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Labourer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

13. NAME Wilhelm Leining

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany

15. MAIDEN NAME unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT (ADDRESS) Hospital information

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Mathew DATE May 6 1932

19. UNDERTAKER (ADDRESS) J. J. Quinn

20. FILED 1932 May 15 1932 City Hospital Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 4th 1932

22. I HEREBY CERTIFY, That I attended deceased from April 17th 1932 to May 4th 1932
I last saw him alive on May 4th 1932 Death is said to have occurred on the date stated above at 3:15 P.M.
The principal cause of death and related causes of importance were as follows:

Myocarditis
apoplectic
left hemiplegia (red)
acute bronchitis
Date of onset _____

23. Name of operation _____ Date of _____
What test confirmed diagnosis? none Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify no
(Signed) M. Thomsen, M. D.
(Address) City Hospital

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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.

V. S. NO. 2

“Lening”