

111-1030  
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  
STANDARD CERTIFICATE OF DEATH

State File No. 40818 ✓

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1979

1. PLACE OF DEATH:  
(a) County. ST LOUIS  
(b) City or town. OVERLAND  
(c) Name of hospital or institution. 3726 CALVERT AVE 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. (Specify whether years, months or days) 5 1/2

3. (a) PRINT FULL NAME. LEO E. MANNHART, JR.  
8. (b) If veteran, name war. \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex. male  
5. Color or race. white  
6. (a) Single, widowed, married, divorced. \_\_\_\_\_  
6. (b) Name of husband or wife. \_\_\_\_\_  
6. (c) Age of husband or wife if alive. 10 years (Day) (Year)  
7. Birth date of deceased. NOV 10 1939 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
3 hr. min.

9. Birthplace. ST LOUIS CO MO (City, town, or county) (State or foreign country)

10. Usual occupation. none

11. Industry or business. \_\_\_\_\_

MOTHER FATHER { 12. Name. LEO E. MANNHART  
18. Birthplace. ST LOUIS MO (City, town, or county) (State or foreign country)

{ 14. Maiden name. RUTH GIBBS  
15. Birthplace. PERRYVILLE MO (City, town, or county) (State or foreign country)

16. (a) Informant's own signature. Leo E. Mannhart  
(b) Address. 3726 Calvert

17. (a) BURIAL (Burial, cremation, or removal)  
(b) Date thereof. NOV 11 1939 (Month) (Day) (Year)  
(c) Place: burial or cremation. CALVARY CEM.

18. (a) Signature of funeral director. DAUMANN BROS.  
(b) Address. OVERLAND MO

19. (a) NOV 11 1939 (Date received local registrar)  
(b) [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State. MISSOURI (b) County. ST LOUIS  
(c) City or town. OVERLAND  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3726 CALVERT  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month NOV 10 day year 39 hour minute M.  
21. I hereby certify that I attended the deceased from NOV 10 1939 to NOV 10 1939 and that I last saw him alive on NOV 10 1939 and that death occurred on the date and hour stated above.

Immediate cause of death. Premature Birth  
Due to  
Due to  
Other conditions. Cardiac insufficiency  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings:  
Of operations  
Of autopsy  
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury  
23. Signature. [Signature] (M. D. or other)  
Address. 8816 S. [Address] Date signed

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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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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 this body is not embalmed, above space should be left blank.**