

No. 2
-13-40
-17-39
X23159

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26887**

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **6783**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Hospital #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Thomas L. Ledencan 352**

3. (b) If veteran, name war **No.** 3. (c) Social Security No. **No**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Jan. 2nd 1879**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
abt. 61	6			hr. min.

9. Birthplace **Europe 7**
(City, town, or county) (State or foreign country)

10. Usual occupation **Barber**

11. Industry or business _____

12. Name **Unknown**

13. Birthplace **Unknown 9**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown 9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Anna LeGrand**

(b) Address **1036 Carroll**

17. (a) **Burial** (b) Date thereof **8-10-40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sunset Burial Park**

18. (a) Signature of funeral director **Oscar J. Hoffmeister**
(b) Address **4016 Chipewa**

19. (a) **AUG 8 1940** (b) **J. T. Breder**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) **0 Missouri** (b) County _____
(c) City or town **St. Louis 22**
(If outside city or town limits, write "RURAL")
(d) Street No. **809 So. Broadway**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: **July** day: **29th**
year **1940** hour **10:25** minute **P.** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death
Gunshot wound of the right side of head; self inflicted in his room at 809 So. Broadway, on July 29th, 1940, at about 9:00 P.M.

Due to _____

Other conditions (Include pregnancy within 5 months of death)

Major findings: Of operations

Of autopsy

Duration

PHYSICIAN

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) **Suicide**

(b) Date of occurrence **July 29th, 1940**

(c) Where did injury occur? **St. Louis, Mo.**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **In Home**

(Specify type of place) While at work? (e) Means of injury **S**

23. Signature **Alfred J. Brown** (M. D. or other) _____
Address **Alfred J. Brown** Date signed **8/9/40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....

Ernest W. Spillers

Licensed Embalmer No.....

14080

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, fact should be so stated above.