DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 40734

Registration District No. 791 1003 Primary Registration District No.

Registrar's No. 10505

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
BARNES HOSPITAL
(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)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis 6
(If outside city or town limits, write "RURAL")

(d) Street No. 4721 Greer
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME William Lesseig

3. (b) If veteran, name war

3. (c) Social Security No. 491-14-4211

4. Sex Male

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Catherine Lesseig

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased May (Month) 15th. (Day) 1867 (Year)

8. AGE: Years 73 Months 7 Days 5 If less than one day hr. min.

9. Birthplace (City, town, or county) Penn. (State or foreign country)

10. Usual occupation Salesman

11. Industry or business Standard Leather Co.

FATHER
12. Name ? Lesseig
13. Birthplace Dont Know (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Dont Know
15. Birthplace Dont Know (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Catherine Lesseig
(b) Address 4721 Greer Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-40 (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles Cemetery

18. (a) Signature of funeral director Proost Bud C.
(b) Address 3710 N. Grand Blvd.

19. (a) DEC 21 1940 (Date received local registrar) (b) F R Biedecke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 20 year 1940 hour 2 minute 25 P. M.

21. I hereby certify that I attended the deceased from November 21, 1940, to December 20, 1940; that I last saw him alive on December 20, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Bronchopneumonia	
Pulmonary infarction	
Uremia	
Due to Arteriosclerotic kidney disease	
Generalized arteriosclerotic heart	
Due to disease	

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy As above

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

23. Signature F R Bradley (M. D. or other)
Address BARNES HOSPITAL Date signed 12-20-40

(Licensed Embalmer's Statement on Reverse Side)

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

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.

1 X19251

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 Kenneth Jones, Registered Apprentice No. 238 working under my personal supervision.

Signed Robert L. Dunkerman

Licensed Embalmer No. 3553

P. O. Address 3710 N Grand St

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.