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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED FEB 27 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 601  
Registrar's No. 480

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:  
(a) County.....  
(b) City or town..... ST. LOUIS  
(c) Name of hospital or institution: JOSEPHINE H. HOSPITAL  
(d) Length of stay: In hospital or institution.....  
In this community.....  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State..... MISSOURI (b) County.....  
(c) City or town..... ST. LOUIS  
(d) Street No. JOSEPHINE HOSPITAL  
3806 SHADW BLV  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME JOSEPHINE LEITNER  
(b) If veteran, name war..... NO  
(c) Social Security No..... NO

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan day 17  
year 1944 hour 6 minute 45 A.M.  
21. I hereby certify that I attended the deceased from.....  
..... 19....., to..... 19.....;

4. Sex FEMALE / 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced INFANT  
6. (b) Name of husband or wife.....  
6. (c) Age of husband or wife if alive..... years  
7. Birth date of deceased: JANUARY 13<sup>th</sup> 1944  
(Month) (Day) (Year)

that I last saw h..... alive on..... 19.....;  
and that death occurred on the date and hour stated above.  
Immediate cause of death.....  
Duration

8. AGE: Years Months Days 4 If less than one day hr. min.

Respiratory failure autopsy does not reveal hemorrhage or tear  
Due to.....  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

9. Birthplace: ST. LOUIS MO  
(City, town, or county) (State or foreign country)  
10. Usual occupation: INFANT

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Major findings:  
Of operations.....  
Of autopsy.....

11. Industry or business  
12. Name PERRY LEITNER  
13. Birthplace MISSOURI  
(City, town, or county) (State or foreign country)  
14. Maiden name RUTH WAGMAN  
15. Birthplace MISSOURI  
(City, town, or county) (State or foreign country)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Perry Leitner  
(b) Address 3806 SHADW BLV  
17. (a) BURIAL (b) Date thereof JAN 17 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

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?

(c) Place: burial or cremation VALLALLA CEMETERY  
18. (a) Signature of funeral director E. J. Schum  
(b) Address 3125 Lafayette St  
19. (a) JAN 17 1944 J. F. Breda  
(Date received local registrar) (Registrar's signature)

While at work?..... (Specify type of place)  
(c) Means of injury.....  
23. Signature John Breda (M. D. or other)  
Address 1715 So 5th St Date signed 1-17-44

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

**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.

*not embalmed*  
Signed *Geo. B. Williams*  
Licensed Embalmer No. *4014*  
P. O. Address *St Louis mo.*

**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.**