

FILED JUN 10 1944

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5104**

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 **14 days**
(Specify whether)

In this community **0**
years, months or days

3. (a) PRINT FULL NAME **Minnie Rose Leckner**

3. (b) If veteran, name war _____

3. (c) Social Security No. **498-01-1181**

4. Sex **Female**

5. Color or race **White**

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

6. (b) Name of husband or wife **Karl Leckner**

6. (c) Age of husband or wife if alive **42** years

7. Birth date of deceased **Oct 26 1906**
(Month) (Day) (Year)

8. AGE: Years **37** Months **6** Days **28**
If less than one day hr. min.

9. Birthplace **St. Louis**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER { 12. Name **Lohn Knopf**

13. Birthplace **Austria Hungaria**
(City, town, or county) (State or foreign country)

14. Maiden name **Agness Windisch**

15. Birthplace **Austria Hungaria**
(City, town, or county) (State or foreign country)

16. (a) Informant **Karl Leckner**

(b) Address **4434 Bessie Ave 1944**

17. (a) Burial **Calvary Cem**
(Burial, cremation, or removal)

(b) Date thereof **June 6 Th**
(Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cem**

18. (a) Signature of funeral director **Edmond Koch**

(b) Address **3516 N. 14 Th Str**

19. (a) JUN 7 1944 **J. F. Bedick**
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County _____

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

(d) Street No. **4834 Bessie Ave**
(If rural, give location)

(e) Citizen of foreign country? **(Yes or No)**
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **2**
year **1944** hour **7** minute **15** P.M.

21. I hereby certify that I attended the deceased from **May 19**, 1944, to **June 2**, 1944,
that I last saw her alive on **June 2**, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death **hemorrhage intracranial**
Duration **1 1/2**

Due to **Chronic Myelogenous Leukemia**

Due to _____

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 **M. C. Adams** (M. D. or other) _____
Address **BARNES HOSPITAL** Date signed **6/3/44**

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

2
33
35697

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 Howard P. Rowland

Licensed Embalmer No. 3114

P. O. Address Olthaus 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.