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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25918

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7672

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: Missouri - Pacific Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 34 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County St. Clair
(c) City or town East St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 709 Post Pl.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No) 2
If yes, name country

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3. (a) PRINT FULL NAME ELMER McLEOD
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ione McLeod
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec. 1, 1889 (Month) (Day) (Year)
8. AGE: Years 55 Months 8 Days 30 If less than one day hr. min.
9. Birthplace Mascutah (City, town, or county) Ill (State or foreign country)
10. Usual occupation Accountant
11. Industry or business
FATHER 12. Name Crittendon McLeod
FATHER 13. Birthplace St. Clair Co. (City, town, or county) Ill (State or foreign country)
MOTHER 14. Maiden name Jane (Not known)
MOTHER 15. Birthplace St. Clair Co. (City, town, or county) Ill (State or foreign country)
16. (a) Informant Chas Burke
(b) Address East St. Louis, Ill
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation East St. Louis, Ill
18. (a) Signature of funeral director Chas Burke
(b) Address East St. Louis, Ill
19. (a) SEP 1 1945 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 31st year 1945 hour 2 minute 23 P.M.
21. I hereby certify that I attended the deceased from July 27th, 19 45, to Aug 31, 19 45, that I last saw him alive on Aug 31, 1945, 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinomatosis — Duration approx 12 months
Due to Carcinoma of descending colon.
Due to
Other conditions 55
(Include pregnancy within 3 months of death)

Major findings:
Of operations Wide spread metastases throughout abdomen
Of autopsy

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 John Crane (M. D. or other)
Address 1755 S. Grand Date signed 8/31/45 St Louis, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

Signed Chas. M. Burke

Licensed Embalmer No. 2421

P. O. Address East St Louis Ill

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.

. No. 2B
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7672

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:
(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 (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Elmer Mc Leod

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec 1 (Month) (Day) (Year)

8. AGE: Years 55 Months 6 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 31 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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. D. or other)
Address Date signed

SUPPLEMENTARY

259118