

S. No. 2
OM-543
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE DEPARTMENT OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39431**
Registrar's No. **11169**

FILED JAN 5 1946
318

Registration District No. _____ Primary Registration District No. **1003**

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

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:
Alexian Bros. Hospital ⁽¹⁾
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 days
(Specify whether In this community years, months or days) 50 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 0019

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") ¹¹⁵

(d) Street No. 5010 Elenore
(If rural, give location)

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

3. (a) PRINT FULL NAME Edward P. Leistritz

3. (b) If veteran, name war _____

3. (c) Social Security No. 495-14-4900

4. Sex male (1) 5. Color or race white

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

6. (b) Name of husband or wife Alice

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased May 26 ¹⁸⁷⁶
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>69</u>	<u>6</u>	<u>23</u>	hr. _____ min. _____

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

10. Usual occupation Contractor

11. Industry or business _____

12. Name Ernst Leistritz

13. Birthplace Germany
(City, town, or county) (State or foreign country) ⁴

14. Maiden name Sophie

15. Birthplace Louisiana
(City, town, or county) (State or foreign country) ¹

16. (a) Informant Harold Leistritz

(b) Address 5010 Elenore

17. (a) Burial (b) Date thereof 12-21-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kampsville, Ill.

18. (a) Signature of funeral director J. F. Ziegenhagen

(b) Address 7027 Gravois Ave.

19. (a) DEC 20 1945 (b) J. F. Berdeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 19
year 1945 hour 10 minute 45 P.M.

21. I hereby certify that I attended the deceased from Dec 4 1945 to Dec 19 1945
and that death occurred on the date and hour stated above.

Immediate cause of death ac dilatation of head
Due to Chronic myocarditis
Duration 6 hrs

Other conditions Head ulcer - a recent gastroenteritis
(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? _____

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

23. Signature Erwin S. Cienkus (M. D. or other)
Address 706 S. Perry, St. Louis, Mo. Date signed 12/24/45

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 *W. G. Peterson*

Licensed Embalmer No. *3767*

P. O. Address *Overland Park, 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.