V. S. No. 2
00M—5-43
Rev. 5-17-39
Form I X36671

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

FILED DEC 28 1945 318 1003

State File No. 39437

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 10901

1. PLACE OF DEATH:

(a) County St. Louis,
(b) City or town St. Louis, Missouri,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John's Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days. (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County St. Louis,
(c) City or town 8337 Elmore Ave., N.R.
(If outside city or town limits, write "RURAL")
(d) Street No. University City,
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME VELDA GLADYS LESINSKI.

3. (b) If veteran, name war None..

3. (c) Social Security No. 487-14-1615.

4. Sex Female.

5. Color or race White.

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

6. (b) Name of husband or wife Edward G. Lesinski.

6. (c) Age of husband or wife if alive 32. years

7. Birth date of deceased April (Month) 22, (Day) 1918. (Year)

8. AGE: Years 27. Months 7. Days 22. If less than one day ____ hr. ____ min.

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

10. Usual occupation Waitress.

11. Industry or business

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

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

16. (a) Informant Edward G. Lesinski.
(b) Address 8337 Elmore Ave.,

17. (a) Burial.. (Burial, cremation, or removal) (b) Date thereof 12-17-45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director C.R.Lupton & Sons.
(b) Address 7233 Delmar Blv'd.

19. (a) DEC 14 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec, day 13th, year 1945. hour 11 minute 20 a M.

21. I hereby certify that I attended the deceased from 12-10 1945 to 12-13 1945 that I last saw her alive on 12-13 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bacterial endocarditis mitral valve. (Strep. Viridans)	Since Sept. 1945
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): Spontaneous miscarriage in Sept. 1945. Prior to	
Major findings: Of operations: none 28 wks.	
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) no.
(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 J. Hammond (M. D. or other) M. D.
Address 634 N. Grand Date signed 12/14/45

(Licensed Embalmer's Statement on Reverse Side)

Dr John J. Hammond,
Mo., Theatre Bld'g.,
FR: 5080
2:30 - 5:30

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 Clarence H. Murray

Licensed Embalmer No. H911

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.