

FILED MAY 16 1946

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4065**

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: **St. Louis City Hospital**
Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

3. (a) PRINT FULL NAME **LEANDER LEBER**

3. (b) If veteran, name war **World War I** 3. (c) Social Security No.....

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**

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

7. Birth date of deceased **September 7 1890**
(Month) (Day) (Year)

8. AGE: Years **55** Months **7** Days **26** If less than one day hr. min.

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

10. Usual occupation **Nil**

11. Industry or business.....

MOTHER FATHER { 12. Name **John Leber** }
13. Birthplace **Franklin Co. Mo.** }
(City, town, or county) (State or foreign country)
14. Maiden name **Anna Rocklage** }
15. Birthplace **Unknown** }
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Ida A. Ott**
(b) Address **7524 N. Broadway**

17. (a) **Burial** (b) Date thereof **May 6, 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **National Cemetery**

18. (a) Signature of funeral director **C. Hoffmeister U. & L. Co.**

(b) Address **7814 S. Broadway**

19. (a) **MAY 4 1946** (b) **J. F. Bredeck**
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **Maple Hotel 112 S. Broadway**
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **MAY** day **3**
year **1946** hour **2** minute **45** A.M.

21. I hereby certify that I attended the deceased from **4-8-46**
..... 19..... to **5-3-46** 19.....
that I last saw h..... alive on **5-2-46** 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death **RESPIRATORY FAILURE**

Due to **PULMONARY TBC, FAR ADVANCED**

Due to.....

Other conditions **AURICULAR FISTULA**
(Include pregnancy within 3 months of death)

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

Duration
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) (c) Means of injury **3**

3. Signature **Leban Stephens** (M.D. or other)
Address **City Hosp.** Date signed **5-3-46**

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

17513

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 Lewis C. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadway

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.