

No. 2  
-12-45  
-17-39  
X47070

**FILED MAR 31 1947**  
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: **1005 HiPoint Pl. /**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community **27 yrs.**  
years, months or days)

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. **1005 HiPoint Pl.**  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **20th.**,  
year **1947** hour **1** minute **15 p.m.**  
21. I hereby certify that I attended the deceased from **6-10** 19**43** to **3-20** 19**47**  
that I last saw **her** alive on **3-27-47** 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death

**9 poplexy**  
Due to **Hypertension**  
**arteriosclerosis**

Duration

**9 days**  
**4 yrs**

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? \_\_\_\_\_

(a) Signature **B.B. Jemmyls** (Specify type of physician) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
(M. D. or other) \_\_\_\_\_  
Address **1116 Mc Carlland** Date signed **3-21-47**

3. (a) PRINT FULL NAME **Nellie R. Leopold**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **F.** / 5. Color or race **W.** 6. (a) Single, widowed, married, divorced **W. 3**

6. (b) Name of husband or wife **Samuel H. Leopold** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **Feb. 10th., 1867**  
(Month) (Day) (Year)

8. AGE: Years **80** Months **1** Days **10** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace **Olean, N.Y. /**  
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

MOTHER FATHER { 11. Industry or business \_\_\_\_\_

12. Name **Patrick Ragan**

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

14. Maiden name **Ellen Crowley**

15. Birthplace **Ireland 4**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Samuel H. Leopold**

(b) Address **1005 HiPoint Pl.**

17. (a) **Removal** (b) Date thereof **3-22-47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Chicago, Ill.**

18. (a) Signature of funeral director **Arthur Donnelly**

(b) Address **3840 Lindell Blvd.**

19. (a) **MAR 21 1947** (b) \_\_\_\_\_ (Registrar's signature)  
(Date received local registrar)

1116 Mrs. Cunningham  
11 Jan 12 1906

**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.H. Van Matre  
Licensed Embalmer No. 2825  
P. O. Address 4340 Lafayette

**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.**