

S. No. 2
1-1/47
5-17-39

National Office of Vital Statistics
FILED DEC 15 1947

State File No.

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 11169

1. PLACE OF DEATH:

(a) County..... St. Louis

(b) City or town..... St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution..... Missouri Baptist Hosp
(If not in hospital or institution, write street, number, or location)

(d) Length of stay: In hospital or institution..... 6 days
(Specify whether 2 Months 22 days (years, months or days))

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County..... -0-0-0

(c) City or town..... St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 1219 Monroe St. 9
24 (If rural, give location) 6

(e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME..... Joan Leslie Licklider

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

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... December 3rd, day..... 3rd, year..... 1947, hour..... 12:30, minute..... PM, M.....

4. Sex..... female 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 11th, 1946
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from..... Nov. 29, 1947, to..... Dec 3, 1947, to..... 19.....

that I last saw him alive on..... Dec 2, 1947, 19.....

and that death occurred on the date and hour stated above. Duration

8. AGE:	Years	Months	Days	If less than one day
	1	2	22 hr. min.

Immediate cause of death..... Pulmonary embolism

Due to..... embolism

Due to..... walnut leaf

Other conditions.....

(Include pregnancy within 3 months of death) III

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

10. Usual occupation..... none

PHYSICIAN

Major findings:
Of operations.....

Of autopsy..... none

Underline the cause of which death should be charged statistically.

11. Industry or business.....

12. Name..... Leslie Licklider

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

14. Maiden name..... Gladys Mitchell

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

16. (a) Informant..... Leslie Licklider

(b) Address..... 1219 Monroe St.

17. (a) Burial..... (b) Date thereof..... 12-6-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Friedens Cemetery

18. (a) Signature of funeral director..... Hy. Leidner U. Co.

(b) Address..... 2223 St. Louis Ave.

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) Means of injury.....

23. Signature..... R. Payne (M. D. or other).....

Address..... Date signed..... 12-5-47

19. (a) DEC 6 - 1947 (b) J. F. Bredack
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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

John P. Buchholz

Licensed Embalmer No.

1674

P. O. Address

2223 St. Louis Ave

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.