

#124892
FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED AUG 12 1948
Registration District No. **318**

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
Primary Registration District No. **1003**

State File No. **24473**
Registrar's No. **6234**

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

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
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution premature
In this community premature infant
years, months or days (Specify whether)

3. (a) PRINT FULL NAME BABY GIRL LEISLER
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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 June 15th, 1948
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 4 If less than one day hr. _____ min. _____

9. Birthplace St. Louis City Hospital (City, town, or county) (State or foreign country)
10. Usual occupation nil

11. Industry or business _____
12. Name Vernon Leisler
13. Birthplace Missouri (City, town, or county) (State or foreign country)
14. Maiden name Catherine Lichtfus
15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Eat Catherine Leisler
(b) Address 4415 S. Main
17. (a) Anatomical Board (Date thereof JUL 31 1948)
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Anatomical Board

18. (a) Signature of funeral director Rowland Mortuary Service
(b) Address 4104 Manchester Ave.
19. (a) JUL 31 1948 (Date received) J. F. Brebeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 4418 S. Main Memorial (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 19th
year 1948 hour 12 minute 45 A. M.
21. I hereby certify that I attended the deceased from June 19th 1948
to June 19th 1948
that I last saw her alive on June 19th 1948
and that death occurred on the date and hour stated above.

Immediate cause of death PREMATURITY Duration _____
Due to UNKNOWN CAUSE

Due to _____
Other conditions (include pregnancy within 3 months of death) 157

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)
Means of injury 0
23. Signature Edward M. Parkin (M.D. or other) M.D.
Address 1515 Lafayette Date signed 6/19/48

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.....

Licensed Embalmer No.....

P. O. Address.....

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.