No. 300
10.48

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

FILED MAY 5 1949

#90810

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13934

State File No. 3733

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

23

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis, Mo.
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Louis City Hospital #1.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Missouri
b. COUNTY: Mo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 2307 S. Broadway

3. NAME OF DECEASED (Type or Print)
a. (First): SOPHIA
b. (Middle):
c. (Last): LEETO

4. DATE OF DEATH (Month) (Day) (Year): April 24, 1949

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 11, 1872
9. AGE (In years last birthday): 77
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Unknown Habraneck
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: George

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: --
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: George Leeto--2307 S. Broadway

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) generalized arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senile dementia

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/14/49, 19___, *to* 4/24/49 19___, *that I last saw the deceased alive on* 4/24/49, 19___, *and that death occurred at* 1:25am m., *from the causes and on the date stated above.*

23a. SIGNATURE Edward W. Czebinski (Degree or title) M.D.
23b. ADDRESS 1515 Lafayette Ave.
23c. DATE SIGNED 4/25/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 4/27/49
24c. NAME OF CEMETERY OR CREMATORY: St. Matthews Cemetery
24d. LOCATION (City, town, or county) (State): St. Louis, Missouri

DATE REC'D BY LOCAL REG.: APR 26
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Wacker-Helderle 3634 Gravois

(Licensed Embalmer's Statement on Reverse Side)

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 _____ Student Embalmer No. _____, working under my personal supervision.

Signed Felix J. Krispin

Licensed Embalmer No. 3497

P. O. Address 3634 Gravois

Signed _____
Student Embalmer

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.