

FILED NOV 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **34885**  
Registrar's No. **9162**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>DePaul Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>4830 Labadie</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Leo</b> b. (Middle) c. (Last) <b>Anderson</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 24, 1949</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <b>Married</b>	8. DATE OF BIRTH <b>Jan. 11, 1896</b>
9. AGE (In years last birthday) <b>53</b>		10. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	11. BIRTHPLACE (State or foreign country) <b>Missouri</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		12. CITIZENSHIP OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Sidney Anderson</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Green</b>	
14. NAME OF HUSBAND OR WIFE <b>Dorothy Anderson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>497-01-8528</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Dorothy Anderson, 4830 Labadie</b>	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Brain Abscess</b> ANTECEDENT CAUSES <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b> DUE TO (b) <b>Septal Abscess</b> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <b>10/22/49</b>		19b. MAJOR FINDINGS OF OPERATION <b>Brain Abscess</b>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b>	
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) <b>128</b>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>6/7X</b>	
22. I hereby certify that I attended the deceased from <b>10/19, 1949</b> , to <b>10/24, 1949</b> , that I last saw the deceased alive on <b>10/23, 1949</b> , and that death occurred at <b>8:15 P m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Admiral A. Smolik, M.D.</b>		23b. ADDRESS <b>Beaumont Med Bldg</b>	23c. DATE SIGNED <b>10/25/49</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>10/27/49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Lake Charles Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
DATE REC'D BY LOCAL REG. <b>OCT 25 1949</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>PROVOST UND. CO., 3710 N. Grand Bl.</b>	

Dr. E. A. Imolite  
Revis. Body  
2:30 - 4:00

Paul

**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 Albert Mayfield

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3077

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.