

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6434

State File No. _____

FILED FEB 17 1950

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		d. STREET ADDRESS (If rural, give location) <u>16 3400 S. Grand Blvd.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Little Sisters of the Poor 3400 S. Grand Blvd.</u>				d. STREET ADDRESS (If rural, give location) <u>16 3400 S. Grand Blvd.</u>			
3. NAME OF DECEASED (Type or Print) <u>Leonora Lee</u>			a. (First) _____ b. (Middle) _____ c. (Last) <u>Lee</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>February 6, 1950</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 17, 1861</u>		9. AGE (In year last birthday) <u>88</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u>	IF UNDER 1 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Decatur, ILL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Kennedy</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Gephford</u>		14. NAME OF HUSBAND OR WIFE <u>Carville Lee</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Sister Henry 3400 S. Grand Blvd.</u>			
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) <u>Arterio. Sclerosis General</u> ANTECEDENT CAUSES <u>Branchitis</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Serious</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u> <u>2 yr</u> <u>5 yrs</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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) <u>St. Louis Mo.</u>		21f. HOW DID INJURY OCCUR? <u>4-5 TB</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>4-5 TB</u>			
22. I hereby certify that I attended the deceased from <u>Feb 6</u> , 19 <u>50</u> to <u>Feb 6</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Feb 1</u> , 19 <u>50</u> , and that death occurred at <u>7 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree of title) <u>Chas. P. Bandy</u>				23b. ADDRESS <u>607 W. Grand</u>		23c. DATE SIGNED <u>7/6/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2/7/50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St Peter & Paul Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>		
DATE REC'D BY LOCAL REG. <u>FEB 6 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Lasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John H. Gebken Sons 2630 Gravois Ave.</u>			

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

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed..... *Robert F. Gubler*

Signed.....
Student Embalmer

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois 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.