S. No. 300
v. 10.48

FILED JAN 19 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2721

State File No. 183

BIRTH NO. 4639-51 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthonys Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2229
d. STREET ADDRESS (If rural, give location): 1017 Frey Avenue

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

4. DATE OF DEATH (Month) (Day) (Year): January 6, 1951

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): S
8. DATE OF BIRTH: January 5, 1951
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days: 1; IF UNDER 24 HRS. Hours: 4 Min.: 32

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

13a. FATHER'S NAME: Michael Leisure
13b. MOTHER'S MAIDEN NAME: Myrtle Holder
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Michael Leisure 1017 Frey Avenue

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) Prematurity

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

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

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? 776X

22. *I hereby certify that I attended the deceased from* Jan 5, 1951, *to* Jan 6, 1951, *that I last saw the deceased alive on* Jan 5, 1951, *and that death occurred at* 9:45 a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): H. G. Moore M.D.
23b. ADDRESS: 912 - 501 8
23c. DATE SIGNED: 1-8-51

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1-8-51
24c. NAME OF CEMETERY OR CREMATORY: Resurrection
24d. LOCATION (City, town, or county) (State): St. Louis County, Missouri

DATE REC'D BY LOCAL REG.: JAN 8 1951
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: McLAUGHLIN FUNERAL HOME, INC. 2301 Lafayette Av

(Licensed Embalmer's Statement on Reverse Side)

Dr. H.G. Moore, MD
917 So. 18th Street

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. Not Embalmed Student Embalmer No. _____

Signed Norman N. Foehler

Signed _____
Student Embalmer

~~Licensed Embalmer No.~~ Funeral Direc

P. O. Address St Louis, MO

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.