

FILED MAY 1 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14397

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2609

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis
c. LENGTH OF STAY (in this place) _____
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Baptist Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY _____
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jennings
d. STREET ADDRESS (If rural, give location) 5705 Janet Avenue

3. NAME OF DECEASED
a. (First) William b. (Middle) A. c. (Last) Leslie
4. DATE OF DEATH (Month) (Day) (Year) March, 18, 1951

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH Aug. 17, 1903 9. AGE (In years last birthday) 47 IF UNDER 1 YEAR Months Days IF UNDER 1 HR. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filing St. Operator 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) Cloner Port, Ky. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME William W. Leslie 13b. MOTHER'S MAIDEN NAME Clela Robinson 14. NAME OF HUSBAND OR WIFE Harriet Leslie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None 16. SOCIAL SECURITY NO. _____ 17. INFORMANT'S SIGNATURE OR NAME Harriet Leslie, 5705 Janet, Ave. ADDRESS _____

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, asthma, etc. It means the disease, injury, or complication which caused death.*
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Ca, Rt frontal temporal lobes of brain
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Bronchogenic Ca. DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Retinal detachment left eye traumatic
Interval between onset and death 2 wks
2 mos
30 yrs +

19a. DATE OF OPERATION 2-25-51 19b. MAJOR FINDINGS OF OPERATION Bronchogenic Ca. Metastases Mediastinal Glands 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) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 162X

22. I hereby certify that I attended the deceased from 1-27, 1951, to 3-18, 1951, that I last saw the deceased alive on 3-18, 1951, and that death occurred at 5:45 P. m., from the causes and on the date stated above.

23a. SIGNATURE John X. Kennedy M.D. C.M. (Degree or title) 23b. ADDRESS 508 No Grand Ave. 23c. DATE SIGNED 3-20-51

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE Mar. 21, 1951 24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery 24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. MAR 20 1951 REGISTRAR'S SIGNATURE J. B. Lester 25. FUNERAL DIRECTOR'S SIGNATURE Math Hermann & Son, Inc. ADDRESS 2161 E. Fair Ave.

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed _____

Glew W. Hayes

Licensed Embalmer No. _____

5737

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.