

FILED SEP 22 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31555**
Registrar's No. **8249**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St John Hospital | | d. STREET ADDRESS (If rural, give location) 3831a Dunnica | |

| | | | | | |
|---|--|---|---|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) Leonard b. (Middle) A c. (Last) Holdenried | | | 4. DATE OF DEATH (Month) (Day) (Year) Sept 16, 1951 | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married | |
| 8. DATE OF BIRTH Dec 11, 1870 | | 9. AGE (In years last birthday) 80 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Floor contractor | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) St Louis County, Mo. | | 12. CITIZEN OF WHAT COUNTRY? USA | |

| | | | | | |
|--|--|--|--|---|--|
| 13a. FATHER'S NAME Henry J Holdenried | | 13b. MOTHER'S MAIDEN NAME Margaret Michel | | 14. NAME OF HUSBAND OR WIFE Katharine Holdenried | |
|--|--|--|--|---|--|

| | | | | | |
|--|--|-------------------------------------|--|---|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Katharine Holdenried 3831a Dunnica | |
|--|--|-------------------------------------|--|---|--|

| | | | | | |
|--|--|---|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*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> | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cirrhosis of liver ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> | | | INTERVAL BETWEEN ONSET AND DEATH 5 years |
|--|--|---|--|--|--|

| | | | | | |
|------------------------|--|----------------------------------|--|---|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) | |
|--|--|--|--|---|--|

| | | | | | |
|---|--|--|--|---------------------------------------|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR 5810 | |
|---|--|--|--|---------------------------------------|--|

22. I hereby certify that I attended the deceased from **March 1948** to **Sept 16, 1951**, that I last saw the deceased alive on **Sept 16, 1951**, and that death occurred at **8:10P** m., from the causes and on the date stated above.

| | | | | | |
|---|--|-------------------------------------|--|---------------------------------|--|
| 23a. SIGNATURE (Degree or title) Walter W. Davis, M.D. | | 23b. ADDRESS 539 N Grand Ave | | 23c. DATE SIGNED 9/18/51 | |
|---|--|-------------------------------------|--|---------------------------------|--|

| | | | | | |
|---|--|--------------------------|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 9/19/51 | | 24c. NAME OF CEMETERY OR CREMATORY SS' Peter & Paul Cem. | |
| | | | | 24d. LOCATION (City, town, or county) (State) St Louis, Mo. | |

| | | | | | |
|---|--|---|--|--|--|
| DATE REC'D BY LOCAL REG. SEP 18 1951 | | REGISTRAR'S SIGNATURE J. Carl Smith M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS L Ziegenhein & Sons 7027 Gravois | |
|---|--|---|--|--|--|

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

Neville B. Frohwitter

Signed.....
Student Embalmer

Licensed Embalmer No.

3696

P. O. Address

2027 Gravois

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.