

FILED DEC 15 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39597

State File No. 10822

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 10822

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10822

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 OR TOWN) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place) 5 Weeks		d. STREET ADDRESS (If rural, give location) 3680 Laclede Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Lee</u> b. (Middle) <u>LeRoy</u> c. (Last) <u>Prost</u>			4. DATE OF DEATH (Month) (Day) (Year) Dec. 6, 1951		
5. SEX M. <u>D</u>	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Apr. 5, 1899		9. AGE (In years last birthday) 52
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miscellaneous		10b. KIND OF BUSINESS OR INDUSTRY Mark Twain Hotel		11. BIRTHPLACE (State or foreign country) Perryville, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Felix Prost	13b. MOTHER'S MAIDEN NAME Frances Dunker	14. NAME OF HUSBAND OR WIFE Kathryn Prost
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes. War # 1	16. SOCIAL SECURITY NO. 488-10-7571	17. INFORMANT'S SIGNATURE OR NAME Mrs. Kathryn N. Prost	ADDRESS 3680 Laclede
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Embolism - coronary</u>		II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death.		about 2 yrs.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Lymphosarcoma</u>		
		DUE TO (c) <u>Thrombocytopenic purpura, hemorrhagic.</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>2nd. 1</u>

22. I hereby certify that I attended the deceased from February, 1950, to December 6, 1951, that I last saw the deceased alive on December 5, 1951, and that death occurred at 12:05A m., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u>	(Degree or title)	23b. ADDRESS <u>20812 Olive Street</u>	23c. DATE SIGNED <u>12/6/51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE <u>12-6-51</u>	24c. NAME OF CEMETERY OR CREMATORY Tower Grove	24d. LOCATION (City, town, or county) (State) Murphysboro, Illinois.
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DATE REC'D BY LOCAL REG. DEC 6 1951	REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Donnelly</u>	ADDRESS <u>3840 Lindell</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*Case # 10822*

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 \_\_\_\_\_

*W. H. VanMatre*

Signed.....  
Student Embalmer

Licensed Embalmer No. 2825

P. O. Address 4348 Lafayette

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.

Affidavits containing erasures will not be accepted; draw one line through error and write above it.

THE STATE BOARD OF HEALTH OF MISSOURI  
BUREAU OF VITAL STATISTICS

39597

State of..... }  
County of..... } ss.

State File No. ....  
Local Registrar's No. 10822

AFFIDAVIT FOR CORRECTION OF A RECORD

On this..... day of....., 194....., before me appears.....  
....., who, upon..... oath, states that the original record of birth  
for **LeRoy Joseph Prost** died **12-6-1951**, 19....., in the State of  
Missouri, and which was filed at..... on....., 19....., should be corrected as follows:

Item No. **3** should read **LeRoy Joseph Prost**  
Instead of..... **Lee Prost**

Item No..... should read.....  
Instead of.....

The above is true to the best of my knowledge, information and belief.  
(SEAL) Affiant *Mrs. Kathryn Prost* Relationship.

3680 Laclede  
Present Address.

Subscribed and sworn to before me this **10** day of *Dec*, 194**5**

My Commission expires **3-4-53** *Paul Sadler* Notary Public.