

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **3041**  
Registrar's No. **0903**

FILED FEB 14 1952

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|   |  |   |   |  |  |   |  |  |         |
|---|--|---|---|--|--|---|--|--|---------|
| BIRTH NO. _____   |  | REG. DIST. NO. _____  |   | PRIMARY REG. DIST. NO. _____   |  | Registrar's No. _____   |  |  |         |
| 1. PLACE OF DEATH<br>a. COUNTY  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE |  |   |  | b. COUNTY  |         |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <b>St. Louis, Missouri</b>   |  |   |   | c. LENGTH OF STAY (In this place)  |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <b>St. Louis</b> |  |  |         |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>St. Louis City Hospital #1</b>  |  |   |   | d. STREET ADDRESS (If rural, give location)<br><b>3225 Montgomery</b>                              |  |   |  |  |         |
| 3. NAME OF DECEASED<br>(Type or Print)  |  | a. (First)<br><b>TONY</b>   |   | b. (Middle)  |  | c. (Last)<br><b>LESCH</b>   |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>JAN. 14. 1952</b>  |         |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed</b>                           |  | 8. DATE OF BIRTH<br><b>Dec. 3, 1865</b>   |  | 9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.<br><b>86</b> |         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>OAA.</b>  |  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OAA.</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Switzerland 5</b>                                   |  | 12. CITIZEN OF WHAT COUNTRY?   |         |
| 13a. FATHER'S NAME<br><b>George Lesch</b>   |  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Sarah</b> |  |  | 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)<br><b>Unknown</b>  |  | 16. SOCIAL SECURITY NO.<br><b>Unknown</b>   |   | 17. INFORMANT'S SIGNATURE OR NAME<br><b>Hospital Record</b>  |  |   |  |  | ADDRESS |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Thrombosis</b><br><br>ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Generalized Arteriosclerosis</b><br><br>DUE TO (c)<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Aspiration Pneumonia</b> |   |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |         |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION  |   |  |  |   |  | 20. AUTOPSY?<br>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)  |         |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21f. HOW DID INJURY OCCUR?<br><b>332X</b>  |  |   |  |  |         |
| 22. I hereby certify that I attended the deceased from <b>1-12-52</b> , 19___, to <b>1-14-52</b> , 19___, that I last saw the deceased alive on <b>1-14-52</b> , 19___, and that death occurred at <b>8:45P</b> m., from the causes and on the date stated above. |  |   |   |  |  |   |  |  |         |
| 23a. SIGNATURE<br><b>F.J. Cotaneros M.D.</b>  |  |   |   | (Degree or title)  |  | 23b. ADDRESS<br><b>1515 Lafayette Avenue</b>  |  | 23c. DATE SIGNED<br><b>1-15-52</b>   |         |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 24b. DATE<br><b>1-31-52</b>   |   | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Anatomical Board</b>                                      |  | 24d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Mo.</b>                              |  |  |         |
| DATE REC'D BY LOCAL REG.<br><b>JAN 30 1952</b>  |  | REGISTRAR'S SIGNATURE<br><b>J. Carl Smith MA</b>  |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>Rowland Mortuary Service</b>                                |  | ADDRESS<br><b>4104 Manchester Ave.</b>  |  |  |         |

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

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**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.....

Signed.....  
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

**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.