

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. ....

7747

FILED SEP 3-1952

318

1003

BIRTH NO. ....

REG. DIST. NO. ....

PRIMARY REG. DIST. NO. ....

Registrar's No. ....

7747

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY 2049	
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, Mo. 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1227 McCausland Ave.		d. STREET ADDRESS (If rural, give location) 1227 McCausland Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) Sarah b. (Middle) G. c. (Last) Leonhardt		4. DATE OF DEATH (Month) (Day) (Year) Aug. 13, 1952	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 15, 1875
9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo. 0
12. CITIZEN OF WHAT COUNTRY? U. S.		13a. FATHER'S NAME Patrick Hynes	
13b. MOTHER'S MAIDEN NAME Margaret Buckley		14. NAME OF HUSBAND OR WIFE Adolph F. Leonhardt	
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 Adolph F. Leonhardt		ADDRESS 1227 McCausland	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Acute Coronary Failure</i> ANTECEDENT CAUSES DUE TO (b) <i>Diabetic Mellitus</i> DUE TO (c) <i>Cerebrovascular of Menus</i> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Fracture R Femur - box injury</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? 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.) Home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis, Mo. 0	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Unknown		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? Fall at Home 174X		22. I hereby certify that I attended the deceased from 1920, to Aug 13, 1952, that I last saw the deceased alive on Aug 13, 1952, and that death occurred at 8:30 p.m., from the causes and on the date stated above.	
23a. SIGNATURE <i>Robert W. D.</i>		23b. ADDRESS 0 Carlson Kelly	
23c. DATE SIGNED 8-14		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE Aug. 16, 52		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly	
DATE REC'D BY LOCAL REG. AUG 14 1952		26. ADDRESS 3840 Kirkell	

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 me

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *W. S. Dyer*

Licensed Embalmer No. 4699

P. O. Address St. Charles, 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.