

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 61

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Richmond Heights 4255		d. STREET ADDRESS (If rural, give location) 118 Lansing
d. FULL NAME OF HOSPITAL OR INSTITUTION Little Sisters of the Poor					
3. NAME OF DECEASED (Type or Print) a. (First) Richard		b. (Middle) J	c. (Last) Leeson		4. DATE OF DEATH (Month) (Day) (Year) 1/2/54
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, 2 WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 2/7/1867	9. AGE (In years last birthday) 86	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Rail Roader		11. BIRTHPLACE (State or foreign country) Shipman Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME James Leeson		13b. MOTHER'S MAIDEN NAME Mary Welch		14. NAME OF HUSBAND OR WIFE Jessie Leeson Dec.	
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 James Leeson 4524 N. Kingshighway		
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) Ch. Myocarditis, Scabiety				INTERVAL BETWEEN ONSET AND DEATH 57 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Acute Upper Respiratory Infection		7 days
	DUE TO (c)		None		
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) None	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) None	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4222			
22. I hereby certify that I attended the deceased from Dec 26, 1953, to Jan 2, 1954, that I last saw the deceased alive on Dec. 30, 1953, and that death occurred at 6:00 a.m., from the causes and on the date stated above.					
23a. SIGNATURE Bernard H. Howe M.D.			23b. ADDRESS 2435 N. Grand Blvd		23c. DATE SIGNED 1-4-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2/5/53	24c. NAME OF CEMETERY OR CREMATORY St. Alphonse Cemetery		24d. LOCATION (City, town, or county) (State) Brighton Ill.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JAN 4 1954 Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE W. Clark		ADDRESS 1125 Hodiament Ave.		

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.....

Alfred J. Bredelke

Signed.....
Student Embalmer

Licensed Embalmer No. 2663

P. O. Address 1123 Hudson

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.