

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35618

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9058

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri 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 (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Louis State Hospital		d. STREET ADDRESS (If rural, give location) 13 5400 Arsenal St. 21390	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) JOSEPH	b. (Middle) SPARK	c. (Last) LEDDY	ct. 4, 1954		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH May 27, 1876	9. AGE (In years last birthday) 78	10. KIND OF BUSINESS OR INDUSTRY Restarant
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		11. BIRTHPLACE (City and State or Foreign Country) Lake Providence, La.		12. CITIZEN OF WHAT COUNTRY U.S.A.	

13a. FATHER'S NAME Joseph Leddy	13b. MOTHER'S MAIDEN NAME Sparks	14. NAME OF HUSBAND OR WIFE Elizabeth Leddy
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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) None	16. SOCIAL SECURITY NO. 493 05 5969a	17. INFORMANT'S SIGNATURE OR NAME Lois Morgan	ADDRESS 731 Fairview, Webs Grove
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fulminating pneumonia, principally left, with lung abscess, left		INTERVAL BETWEEN ONSET AND DEATH 10 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Far advanced arteriosclerosis, with encephalomalacia		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 49-3x

22. I hereby certify that I attended the deceased from Oct. 25, 19 48, to Oct. 4, 19 54, that I last saw the deceased alive on Oct. 4, 19 54, and that death occurred at 2:20p m., from the causes and on the date stated above.

23a. SIGNATURE R. Hornailler M.D.	(Degree or title) (23b. ADDRESS 5400 Arsenal St.	23c. DATE SIGNED 10/4/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Oct. 6, 1954.	24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REG. OCT 6 1954	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Alexander & Sons	ADDRESS 6175 Delmar Blvd
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(Licensed Embalmer's Statement on Reverse Side)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Ben Affmar

Licensed Embalmer No. *74366*

P. O. Address *St Louis*

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.