

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo.		b. COUNTY St. Louis	
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 3 Days		c. CITY OR TOWN Rock Hill 463 1/1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital		e. STREET ADDRESS (If rural, give location) 2901 Wingate Court			
3. NAME OF DECEASED (Type or Print)		a. (First) JAMES		b. (Middle) NICKOLAOS	
		c. (Last) LEONARD		4. DATE OF DEATH (Month) (Day) (Year) 10-3-1954	
5. SEX M		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 7-1-1924		9. AGE (In years last birthday) 30		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 2 HRS. Hours Min.		11. BIRTHPLACE (City and State or Foreign Country) E. St. Louis Ill		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME N. James Leonard		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Sara Leonard	
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. 348-16-8123		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sara Leonard 2901 Wingate Ct.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH	
		<p>ANTECEDENT CAUSES</p> <p>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</p>			
		<p>DUE TO (b) Hypertensive Ht Disease</p> <p>DUE TO (c) Diabetes Mellitus nephrosclerosis</p>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) 443X	
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?	
22. I hereby certify that I attended the deceased from 9-5-1953 to 0-3-1954 that I last saw the deceased alive on 0-3-1954, and that death occurred at 7:35 a.m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Michael M Karl M.D.		23b. ADDRESS 465 - Maple Ave.		23c. DATE SIGNED 10-4-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE 10-4-1954		24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	
		24d. LOCATION (City, town, or county) (State) St. Louis Mo.			
DATE REC'D BY LOCAL REG. OCT 4 1954		REGISTRAR'S SIGNATURE J. Carl Smith		FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. Parker Aldrich 7 Home Webster Groves	

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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 *no embalming*, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Leslie Welch*

Licensed Embalmer No. *439*

P. O. Address *Wichita, Kan.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.