

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13603

State File No. ....

3104

FILED APR 28 1955

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. ....

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. ....	
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. LENGTH OF STAY (in this place) 77 yrs		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer Phillips Hospital				e. STREET ADDRESS (If rural, give location) 8721 Halls Ferry Road			
3. NAME OF DECEASED (Type or Print) a. (First) Edgar		b. (Middle) T		c. (Last) Leussler		4. DATE OF DEATH (Month) (Day) (Year) April 6 1955	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Nov 4 1877	
9. AGE (In years last birthday) 77		10. UNDER 1 YEAR Months _____ Days _____		11. UNDER 24 HRS. Hours _____ Mins. _____		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inmate Altenheim		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME August Leussler			13b. MOTHER'S MAIDEN NAME Bertha Lang			14. NAME OF HUSBAND OR WIFE Elda Frohard Leussler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. E. Wehrenbrecht, 8721 Halls Ferry Rd			
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Subdural and subarachnoid hemorrhage of brain; suffered in fall to sidewalk in the vicinity of Halls Ferry and Broadview, about 3:45 pm., April 1st 1955. II. OTHER SIGNIFICANT CONDITIONS Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION Accident				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT (Specify) <del>Stroke</del> Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) St. Louis Mo		21d. (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) Apr 1 55 3:45 p.m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? E9035			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 300A m., from the causes and on the date stated above. 44							
23a. SIGNATURE (Degree or title) Patrick J. Taylor Carmel				23b. ADDRESS 1300 Clark		23c. DATE SIGNED 4.7.55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE April 6 1955		24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG APR 7 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Reiderwieden F.H. Inc., 1936 St. Louis Av.			

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

working under my personal supervision..

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed  \_\_\_\_\_

Licensed Embalmer No. 450

P. O. Address St Louis

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.