

FILED NOV 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38376**
Registrar's No. **9598**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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) St. Louis		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (In this place)		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: 409a N. Sarah		e. STREET ADDRESS (If rural, give location) 409a N. Sarah 21970	

3. NAME OF DECEASED (Type or Print)	a. (First) LEONARD	b. (Middle) L.	c. (Last) HOLLE	4. DATE OF DEATH (Month) (Day) (Year) Nov. 1 1955
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, / WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 8-7-1895	9. AGE (In years last birthday) 60	10. UNDER 1 YEAR Months	11. UNDER 2 HRS. Hours	12. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (City and State or Foreign Country) New York, New York	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Edward Holle	13b. MOTHER'S MAIDEN NAME Julia Brady	14. NAME OF HUSBAND OR WIFE Cleo Holle
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Cleo Holle, 409a N. Sarah	ADDRESS
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma stomach		
	ANTECEDENT CAUSES DUE TO (b) DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 151x	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **April 24, 1953**, to **Nov 1, 1955**, that I last saw the deceased alive on **Nov 1, 1955**, and that death occurred at **9:30A m.**, from the causes and on the date stated above.

23a. SIGNATURE Lewis Littmann MD	23b. ADDRESS 8231 Clayton Rd (17)	23c. DATE SIGNED 11-3-55
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24a. BURIAL CREMATION REMOVAL (Specify) Burial	24b. DATE 11-4-1955	24c. NAME OF CEMETERY OR CREMATORY St. Matthews Cem.	24d. LOCATION (City, town, or county) (State) St. Louis Missouri
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DATE REC'D BY LOCAL REG. NOV 3 1955	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE McLaughlin F.H., Inc.	ADDRESS 2301 Lafayette
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNEADING 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 *James R. Chapman*.....
Licensed Embalmer No. *45*.....

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.