

FILED DEC 18 1956

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 43516

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10854

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Minnesota b. COUNTY Hennepin	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Minneapolis <i>8220</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital		d. STREET ADDRESS 2000 (If outside, give location) 21st Ave. N	
Length of stay in hb DOA		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Leo Allen Mayer			4. DATE OF DEATH Month Day Year Nov. 27, 1956		
5. SEX Male <input type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1883		9. AGE (In years last birthday) 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Foreman		10b. KIND OF BUSINESS OR INDUSTRY Flour Mill		11. BIRTHPLACE (City and state or country) Delano, Minn.	
13. FATHER'S NAME Louis Mayer			14. MOTHER'S MAIDEN NAME Unknown		

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. 472-01-4148	17. INFORMANT Address Joseph Mayer, West Broadway	
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18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thromboses Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) 420.1		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE

21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at 12:30 A.M. on the _____ stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) <i>Albert H. Hoppe</i>	22b. ADDRESS 1300 Clark Ave	22c. DATE SIGNED 11/27/56

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11-27-56	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Minneapolis, Minn.
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington	25. DATE RECD. BY LOCAL REG. NOV 27 1956	26. REGISTRAR'S SIGNATURE <i>Paul Smith</i>	

(Licensed Embalmer's Statement on Reverse Side)

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lic
vice00
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diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Eltonoff Penulera*.....

Licensed Embalmer No. *42*.....

P. O. Address *St. Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.