THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUL 26 1957

26307

STATE FILE NUMBER 6428

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

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY ✓
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St.Louis — Inside Limits Yes ☒ No ☐	c. CITY OR TOWN St.Louis — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 09 DePaul Hospital — Length of stay in 1b 6-days	d. STREET ADDRESS (If outside, give location) 211 4058 St.Louis Ave. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First: John	Middle:	Last: Leonard
4. DATE OF DEATH	Month: July	Day: 8	Year: 1957
5. SEX: M.	6. COLOR OR RACE: W.	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Oct.14,1878
9. AGE (In years last birthday): 78	IF UNDER 1 YEAR: Months 8 Days 24	IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ins.Agent, John Hancock	10b. KIND OF BUSINESS OR INDUSTRY: Ins.Co.	11. BIRTHPLACE (City and state or country): Ireland 4	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John Leonard		14. MOTHER'S MAIDEN NAME: Helen Lonergan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 494-07-4391	17. INFORMANT Address: Mrs.Margaret Leonard, 4058 St.Louis Ave.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Myocardial Failure	6 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic Heart Disease	10 yrs.
DUE TO (c)	Portal Cirrhosis	6 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cholecystitis, (Hydrops) 420.0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 7-4-57, to 7-8-57 and last saw ~~her~~ him alive on 7-8-57

Death occurred at 10:15 pm. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): H. O. Schrepel M.D.	22b. ADDRESS: 634 No. Grand, St. Louis Mo	22c. DATE SIGNED: 7-9-57
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: July 11,1957	23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St.Louis,Missouri		
24. FUNERAL DIRECTOR: Arthur J. Donnelly	ADDRESS: 3840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG.: JUL 10 '57
26. REGISTRAR'S SIGNATURE: J. Earl Smith M.D.		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

...iseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was en

by ~~me, or by~~ ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.