

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038497
STATE FILE NUMBER

35015-58
FILED OCT 23 1958 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2636

S. 300
v. 1-57

BIRTH # 11237

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY													
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lemay</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>ST LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>											
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>37 Fuller Home</u>			Length of stay in 1b <u>3 mo</u>		d. STREET ADDRESS (If outside, give location) <u>#169, 3166 ALFRED</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY LEISTNER</u>				4. DATE OF DEATH Month Day Year <u>10-13-58</u>													
5. SEX <u>F</u>		6. COLOR OR RACE <u>wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 18 58</u>		9. AGE (In years last birthday) <u>0</u>		10. FUNDER 1 YEAR Months Days Hours Min. <u>14 25</u>		11. IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>ST LOUIS</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13a. FATHER'S NAME <u>WALTER LEISTNER</u>				13b. MOTHER'S MAIDEN NAME <u>Loiise DEGNAN</u>				14. NAME OF HUSBAND OR WIFE <u>NONE</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>WALTER LEISTNER 3166 ALFRED</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus</u>										INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>meningococcal, lumbar region</u>			DUE TO (c) <u>congenital malformation</u>			751X			(present at birth)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 <u>9-22-58</u> to <u>10-9-58</u> and last saw her alive on <u>10-9-58</u> Death occurred at <u>1205 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.																	
22a. SIGNATURE (Degree or title) <u>Leaer D. Dutcher, M.D.</u>				22b. ADDRESS <u>8515 Delmar St Louis 24 Mo</u>				22c. DATE SIGNED <u>Oct 13, 1958</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE <u>10-14-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAK GROVE</u>			23d. LOCATION (City, town, or county) (State) <u>ST LOUIS CO MO</u>									
24. FUNERAL DIRECTOR ADDRESS <u>ORTMAN F HOME OVERLAND MO</u>				25. DATE RECD. BY LOCAL REG. <u>10-14-58</u>				26. REGISTRAR'S SIGNATURE <u>Herbert P. Donke M.D.</u>									

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Al E. Ortman*

Licensed Embalmer No. *3478*

P. O. Address

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.