

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-041866

State File No.

86177-27
FILED DEC 25 1958

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003 Registrar's No. 10792

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis 15		c. LENGTH OF STAY (In this place) 2 hrs + 43 min		c. CITY OR TOWN Bellefontaine Neighbors	
d. FULL NAME OF HOSPITAL OR INSTITUTION 07 Christian Hosp.		e. STREET ADDRESS 27 10525 Toelle Lane		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) Baby Girl		b. (Middle) Leonard		c. (Last) Leonard	
4. DATE OF DEATH (Month) (Day) (Year) Nov - 10 - 58		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH Nov - 10 - 58		9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 2 42	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Robert Cyril Leonard		13b. MOTHER'S MAIDEN NAME Lois June Weatherhead	
14. NAME OF HUSBAND OR WIFE none		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. none	
17. INFORMANT'S SIGNATURE OR NAME Robert Leonard		18. ADDRESS 10525 Toelle Lane		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, asthenia, etc. It means the disease, injury, or complication which caused death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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)	
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?	
22. I hereby certify that I attended the deceased from 11-10, 1958, to 11-10, 1958, that I last saw the deceased alive on 11-10, 1958, and that death occurred at 8:00 A.M., from the causes and on the date stated above.					
23a. SIGNATURE Kenneth V Larsen M.D.		23b. ADDRESS 607 N. Grand		23c. DATE SIGNED 11-10-58	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 11/11/58		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE DIEBRICH FUNERAL HOME, 8319 Hallsferry		ADDRESS	

M. J. B.

(Licensed Embalmer's Statement on Reverse Side)

*Not embalmed
E. H. Schneider*

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.....

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.**