

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023133
STATE FILE NUMBER

FILED JUL 1 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. 5719

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hosp.</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>807-a Clara</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Leidner</u>			4. DATE OF DEATH Month Day Year <u>June 16 1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ladies Garments</u>	9. AGE (In years last birthday) <u>70</u> IF UNDER 1 YEAR: Months: Days IF UNDER 24 HRS.: Hours: Min.
11. BIRTHPLACE (City and state or country) <u>Germany - Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Unk. Leidner</u>		13b. MOTHER'S MAIDEN NAME <u>Unk. See</u>	14. NAME OF HUSBAND OR WIFE <u>Dena</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT Address <u>Dena Leidner 807 Clara</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>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>CORONARY ARTERY HEART DISEASE</u> DUE TO (c) <u>4201H</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CARCINOMA OF LARYNX, PROSTATIC ENLARGEMENT</u>			INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> <u>4 years.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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>DEC 13, 1947</u> to <u>JUN 16, 1959</u> and last saw him alive on <u>JUN. 15, 1959</u> Death occurred at <u>ABOUT 2:30 AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			22c. DATE SIGNED <u>6/16/59</u>
22a. SIGNATURE <u>Edward M.D.</u> (Degree or title)		22b. ADDRESS <u>539 N. GRAND, ST. LOUIS, MO</u>	22c. DATE SIGNED
23a. BURIAL, CREMATION, or other disposition (Specify) <u>Removal</u>	23b. DATE <u>6/17/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesed Shel Emeth</u>	23d. LOCATION (City, town, or county) (State) <u>University City Missouri</u>
24. FUNERAL DIRECTOR <u>Berger Memorial 4715 McPherson Ave.</u>		25. DATE RECD. BY LOCAL REG. <u>JUN 16 '59</u>	26. REGISTRAR'S SIGNATURE <u>Loard Smith, M.D.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

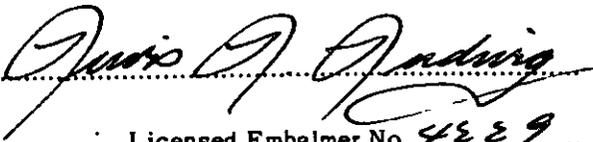
MEDICAL CERTIFICATION

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.

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. 4229
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.**