

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023137  
STATE FILE NUMBER

JUL 1 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **5819**

300  
1-57  
1  
795  
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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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		c. CITY OR TOWN <b>St. Louis, Mo.</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis State</b>		d. STREET ADDRESS (If outside, give location) <b>5235 Thekla St.</b>	
3. NAME OF DECEASED (Type or print) First <b>AUGUST</b> Middle Last <b>LESTICK</b>		4. DATE OF DEATH Month <b>June</b> Day <b>17th</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-9-98</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>formerly: Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY	10c. AGE (In years last birthday) <b>61</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Michael Lestick</b>		13b. MOTHER'S MAIDEN NAME <b>Frances (McClusky)</b>	
14. NAME OF HUSBAND OR WIFE <b>Grace Lestick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>DON'T KNOW</b>	
17. INFORMANT <b>GRACE LESTICK</b>		Address <b>3714 NELSON DR</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonia, severe, bilateral</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Volvulus of jejunum and ileum, due to fibrous peritoneal adhesions</b> DUE TO (c) <b>Syphilitic aortitis and aortic valvulitis.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>570-38</b>			INTERVAL BETWEEN ONSET AND DEATH
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 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 <b>Sept. 28, 1942</b> to <b>June 17th, 1959</b> and last saw <sup>her</sup> him alive on <b>June 17th, 1959</b> Death occurred at <b>11:25</b> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>John H. McMahon M.D.</b>		22b. ADDRESS <b>5400 Arsenal St.</b>	
22c. DATE SIGNED <b>6-17-59</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>6/19/59</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>ST LOUIS MISSOURI</b>	
24. FUNERAL DIRECTOR <b>STROOT - CARROLL</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 19 '59</b>	
ADDRESS <b>4600 NATURAL BRIDGE</b>		26. REGISTRAR'S SIGNATURE <b>Loard Smith, M.D.</b> <b>m88</b>	

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 *M. W. Rueter* .....

Licensed Embalmer No. *4865* .....  
P. O. Address *St Louis, Mo* .....

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.