

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030952

FILED VS AUG 26 1959

Registration District No. **817** Primary Registration District No. **341** Registrar's No. **2190** STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY St. Louis		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 Town & Country CLAYTON DoA.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. St.L.Co.Hospt.		d. STREET ADDRESS (If outside, give location) 2128 A St.LouisAve.	

3. NAME OF DECEASED (Type or print) First John Middle Francis Last Leskey			4. DATE OF DEATH Month 8 Day 13 Year 59		
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 29/84	9. AGE (last birthday) 74	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Laborer	11. BIRTHPLACE (City and state or country) St. Louis	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Charles Leskey		13b. MOTHER'S MAIDEN NAME Catherine Nahn	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 Address Jeanette Graham 2128 a St. Louis		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown natural cause		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____ DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 _____, to _____ and last saw her/him alive on _____
Death occurred at **8:27P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [Signature] (Dedee or title) Commissioner of Health	22b. ADDRESS 801 S. Brentwood Clayton, Mo.	22c. DATE SIGNED 8/18/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8/17/59	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis MO
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24. FUNERAL DIRECTOR Robert D. Kinealy	ADDRESS 2228 St. Louis Ave.	25. DATE RECD. BY LOCAL REG. 8-14-59	26. REGISTRAR'S SIGNATURE [Signature]
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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