# MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS MAR 13 1961

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1961 STATE FILE NUMBER 61-011769

AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

5

BY AFFIDAVIT OF DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Mo.
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Cardinal Glennon Memorial Hospital for Children
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY: St. Louis
c. CITY OR TOWN: Berkeley
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 9447 Trefore
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Leon; Middle: ; Last: White
4. DATE OF DEATH: Month 2 Day 24 Year 61
5. SEX: Male
6. COLOR OR RACE: White
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8-30-59
9. AGE (last birthday): 1
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Lillian Thomas White
14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Marie Rothwell Address: 4140 Lindell Blvd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malnutrition — INTERVAL BETWEEN ONSET AND DEATH (3)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 286.5
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 2-21-61 to 2-24-61 and last saw her/him alive on 2-23-61
Death occurred at 1:55 AM 2-24-61 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): R. James Vaccarella, M.D.
22b. ADDRESS: 1465 S. Grand
22c. DATE SIGNED: 2-25-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 2-28-61
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Missouri

24. FUNERAL DIRECTOR: Cullen & Kelly ADDRESS: 7267 Natural Bridge
25. DATE RECD. BY LOCAL REG.: FEB 27 1961
26. REGISTRAR'S SIGNATURE: Howard Smith, M.D.

**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 Not Embalmed, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James A. Lammers

Licensed Embalmer No. ~~[illegible]~~

P. O. Address St. Louis

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.