

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-015369

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4033

STATE FILE NUMBER

AMENDED

FILED MAY 10 1961

| | | | | | | |
|---|---|---|---|--|--|--|
| 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, Missouri.</u> | | Length of stay in 1b <u>DOA</u> | c. CITY OR TOWN <u>St. Louis</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Enroute City Hospital</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>702 South Broadway</u> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Ray Lesner</u> | | | 4. DATE OF DEATH Month Day Year <u>April 25 1961</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>8/10/1896</u> | 9. AGE (last birthday) <u>64</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio Dispatcher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Great Lakes Towing</u> | | 11. BIRTHPLACE (City and state or country) <u>Detroit, Michigan</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Phillip Lesner</u> | | 13b. MOTHER'S MAIDEN NAME <u>Unavailable</u> | | 14. NAME OF HUSBAND OR WIFE <u>H. Aileen</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unavailable</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | 17. INFORMANT Address <u>Mrs. Marian A. Nipperberg, 3709 40th St. Moline, Illinois.</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 Occlusion;</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) <u>4201</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 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 | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 a.m. p.m. Month, Day, Year | | | | | | |
| 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 _____ <u>11:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>James E. Doyle</u> | | | 22b. ADDRESS <u>1700 Ch...</u> | | 22c. DATE SIGNED <u>4/27/61</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>4/27/61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Local</u> | | 23d. LOCATION (City, town, or county) (State) <u>South Rockwood, Michigan.</u> | |
| 24. FUNERAL DIRECTOR <u>Albert H. Hoppe Inc., 4700 Washington Blvd.,</u> | | | ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>APR 27 1961</u> | 26. REGISTRAR'S SIGNATURE <u>Lois Smith, M.D.</u> | |

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 Elton H. Remeluis

Licensed Embalmer No. 4283

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.