

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-019823

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 1234

AMENDED

FILED MAY 19 1961

DATE AMENDED

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Valley Park, Mo.</u>		Length of stay in 1b <u>MONS</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Valley Park Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6626 Idaho</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward P. Leonard</u>			4. DATE OF DEATH Month Day Year <u>May 1, 1961</u>		
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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>Aug. 27, 1887</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Policeman St. Louis Police Dept.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Missouri</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Unk. Leonard</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Cecelia Leonard</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT Address <u>Cecelia Leonard 6626 Idaho, St. Louis Mo.</u>
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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>Amptropic Lateral Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>356.1</u>		

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 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.)
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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
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21. I attended the deceased from <u>Sept. 19, 1960</u> to <u>May 1, 1961</u> and last saw ^{her} him alive on <u>Apr. 27, 1961</u> Death occurred at <u>11:45 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Robert A. Sanders, M.D.</u>	22b. ADDRESS <u>1502 Cass Av</u>	22c. DATE SIGNED <u>5-2-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-4-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>sunset Burial Park</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Southern Funeral Home</u> <u>6322 S. Grand, St. Louis, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>5-3-61</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

Dr Robt Sanders

1502 Cass

Ch 1-9316

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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 David Van Fossan

Licensed Embalmer No. 4242

P. O. Address 57 Louis Ave

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.