

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-044527

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10648**

DO NOT WRITE ON THIS STUB

AMENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 307 S. Euclid Ave.
			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) Sister Mary Alacoque Leonard RSM			4. DATE OF DEATH 11-4-62		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-21-84	9. AGE (last birthday) 78 Yrs.	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Religious		10b. KIND OF BUSINESS OR INDUSTRY Sister of Mercy	11. BIRTHPLACE (City and state or country) Ballonrobe Co, Ireland	12. CITIZEN OF WHAT COUNTRY U. S.	
13a. FATHER'S NAME John Leonard		13b. MOTHER'S MAIDEN NAME Mary Lyons		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) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Sister Superior, St. John's Hospital		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cerebral infection		10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (b) Acute Brain syndrome due to cerebral arterial thrombosis	10 days	
DUE TO (c) Cerebral arteries occluded	for years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
		332X

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT SUICIDE HOMICIDE No No No	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 10-25-62 to 11-4-62 and last saw her alive on 11-4-62 Death occurred at 9 pm. m on the date stated above, and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) John Hammond M.D.	22b. ADDRESS 634 N. Grand	22c. DATE SIGNED 11/6/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-7-62	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
23d. LOCATION (City, town, or county) St. Louis, Missouri	24. FUNERAL DIRECTOR White-Mullen 118 N. Florissant Rd. Ferg.	25. DATE RECD. BY LOCAL REG. NOV 7 1962
26. REGISTRAR'S SIGNATURE Loan Smith. 17.0: ✓		

VS 300 Rev. 4/59	DATE AMENDED 11-8-62								
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS									
INSTEAD OF									
DOCUMENT									
MEDICAL CERTIFICATION									
BY AFFIDAVIT OF									
ITEM NO.	SHOULD READ								

USE BLACK INK OR TYPEWRITER RIBBON

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

Reinhold K. Lehmann

Licensed Embalmer No.

3395

P. O. Address

St Louis 85 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.