DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 20 1945

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 724

Primary Registration District No. 1003

Registrar's No. 230

1. PLACE OF DEATH:

(a) County

(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: FIRMIN DESLOGE HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 0 (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DEACESED:

(a) State MISSOURI (b) County

(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")

(d) Street No. 2355 ALBION PLACE
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Saneke, Leo

3. (b) If veteran, name war NO

3. (c) Social Security No.

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife GERTRUDE SANEKE

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased NOV. 1 1890 (Month) (Day) (Year)

8. AGE: Years 54 Months 2 Days 7 If less than one day hr. min.

9. Birthplace ST. THOMAS (City, town, or county) NO (State or foreign country)

10. Usual occupation NIL

11. Industry or business

MOTHER FATHER

12. Name JOHN SANEKE

13. Birthplace MO. (City, town, or county) (State or foreign country)

14. Maiden name GERTRUDE LEAVEN

15. Birthplace MO. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Gertrude Saneke

(b) Address 2355 Albion Place

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 11 45 (Month) (Day) (Year)

(c) Place: burial or cremation MARY'S HOME MO

18. (a) Signature of funeral director E. J. Schnur

(b) Address 3125 Lafayette Av.

19. (a) JAN 9 1945 (Date received local registrar) J. Friedel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 8th year 1945 hour 1 minute 45 A. M.

21. I hereby certify that I attended the deceased from December 18th 1944 to January 8 1945 that I last saw him alive on January 8th 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypertensive cardio-vascular and renal disease.	uncertain
Due to: arteriosclerosis	uncertain
Due to: Uremia	
Other conditions (Include pregnancy within 3 months of death): Lung abscess (Rt), Septic infarction of Rt lung.	uncertain

Major findings:
Of operations —

Of autopsy Confirmed by autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Roscoe P. Carney Jr (M. D. or other)

Address Firmin Desloge Hospital Date signed 1-9-45

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Jos B. Kollmer

Licensed Embalmer No. 4014

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.