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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-019379
STATE FILE NUMBER

FILED MAY 26 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 3 4301

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St.Louis — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN St.Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) De Paul Hospital — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 8041 Church Rd., — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print)	First JACQUELYN	Middle FRANCES	Last LEIS	4. DATE OF DEATH Month April Day 30th, Year 1959
5. SEX female	6. COLOR OR RACE white	7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]	8. DATE OF BIRTH January 28th 1937	9. AGE (In years last birthday) 22 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St.Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Chester Leis	13b. MOTHER'S MAIDEN NAME Loretta Beyers	14. NAME OF HUSBAND OR WIFE none		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 488-40-2603	17. INFORMANT Chester Leis, Address 8041 Church Rd.,		

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) Uremia

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) chronic nephritis with aplastic bone marrow

DUE TO (c) Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH: 2 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 260X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X] 2

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 Nov. 1, 1958, to April 30, 1959 and last saw her/him alive on April 30, 1959. Death occurred at 10:40 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert Potashnick M.D.	22b. ADDRESS 3720 Washington	22c. DATE SIGNED 5/1/59
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 5/4/59	23c. NAME OF CEMETERY OR CREMATORY New Bethelhem Cemetery
23d. LOCATION (City, town, or county) (State) St.Louis Co., Mo.		
24. FUNERAL DIRECTOR ADDRESS DIEDRICH FUNERAL HOME, 8319 Hallsferry	25. DATE RECD. BY LOCAL REG. MAY 1 '59	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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.