

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27950
Registrar's No. 7594

FILED SEP 13 1948

Registration District No. 1

Primary Registration District No.

1. PLACE OF DEATH:

(a) County SAINT LOUIS:
(b) City or town SAINT LOUIS:
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: MISSOURI BAPTIST HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME HENRY W. LEYHE

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED
6. (b) Name of husband or wife MAI SPARKS LEYHE 6. (c) Age of husband or wife if alive DECEASED
7. Birth date of deceased MAY 16 1869
(Month) (Day) (Year)

8. AGE: Years 79 Months 3 Days 13 If less than one day hr. _____ min. _____

9. Birthplace WARSAW ILLINOIS
(City, town, or county) (State or foreign country)

10. Usual occupation CAPTAIN & OPERATOR

11. Industry or business MISSISSIPPI RIVER STEAM BOATS

MOTHER FATHER { 12. Name WILLIAM LEYHE 13. Birthplace GERMANY
(City, town, or county) (State or foreign country)
14. Maiden name MARY GODDERTZ 15. Birthplace GERMANY
(City, town, or county) (State or foreign country)

16. (a) Informant WM. H. LEYHE
(b) Address 405 WESTGATE AVE.

17. (a) BURIAL (b) Date thereof AUG 31/48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation OAK GROVE CEMETERY.

18. (a) Signature of funeral director C. R. LUPTON & SONS.
(b) Address 7233 DELMAR BLVD

19. (a) AUG 30 1948 (b) J. F. Bradack
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI: (b) County ST. LOUIS:
(c) City or town UNIVERSITY CITY:
(If outside city or town limits, write "RURAL")
(d) Street No. 405 WESTGATE AVE:
(If rural, give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8- day 3- year 18 hour 3- minute 30 M.

21. I hereby certify that I attended the deceased from 8-1-48 to 8-29-48, 19____
that I last saw h. _____ alive on 8-29-48, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion
Hypertension
Due to Arterio-sclerosis
Renal
Due to Chronic hypertension

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of 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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature R. Andrews (M. D. or other)
Address Beaumont Bldg Date signed 8/30/48

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.....

Clarence H. Murray

Licensed Embalmer No.....

4011

P. O. Address.....

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