

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

38978

State File No. 1003  
 Registrar's No. 9703

FILED NOV 25 1949

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 9703	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ILLINOIS b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR SAINT LOUIS		c. LENGTH OF STAY (In this place) 43 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN: JERSEYVILLE			
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital, <i>NR</i>				d. STREET ADDRESS (If rural, give location) 711 NORTH STATE STREET			
3. NAME OF DECEASED (Type or Print) a. (First) MARY		b. (Middle) T.		c. (Last) LEIGH		4. DATE OF DEATH (Month) (Day) (Year) NOVEMBER 9, 1949	
5. SEX FEMALE /		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married /		8. DATE OF BIRTH March 16, 1889	
				9. AGE (In years last birthday) 60		IF UNDER 1 YEAR Months Days IF UNDER 4 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Jerseyville, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Anthony Quinn			13b. MOTHER'S MAIDEN NAME Catherine McGrath			14. NAME OF HUSBAND OR WIFE Walter Leigh	
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. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Martha Bowen, 1522 So. Rock Hill Rd.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Adeno carcinoma of Sigmoid Colon</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 18 mos.	
19a. DATE OF OPERATION 9.20.49		19b. MAJOR FINDINGS OF OPERATION Tumor mass Sigmoid with widespread metastases?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Holt			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 133 X			
22. I hereby certify that I attended the deceased from Sept 27, 1949, to Nov. 9, 1949, that I last saw the deceased alive on Nov. 9, 1949, and that death occurred at 4:45 P.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <i>Dr. R. ...</i>				23b. ADDRESS Barnes Hospital.		23c. DATE SIGNED 11-9-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11-9-49		24c. NAME OF CEMETERY OR CREMATORY Oak Grove		24d. LOCATION (City, town, or county) (State). Jerseyville, Ill.	
DATE REC'D BY LOCAL REG. NOV 10 1949		REGISTRAR'S SIGNATURE <i>J. Hoppe</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd			

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

MAR 17 1950

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 \_\_\_\_\_  
Student Embalmer

Signed \_\_\_\_\_

*J. W. Dublin*  
Licensed Embalmer No. *3653*

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