

STANDARD CERTIFICATE OF DEATH

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

State File No. **10240**
Registrar's No. **2864**

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, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS (If rural, give location) 5823 Theodore Ave.	
3. NAME OF DECEASED (Type or Print) a. (First) Margaret b. (Middle) c. (Last) Leach		4. DATE OF DEATH (Month) (Day) (Year) 3 25 52	
5. SEX Fem /	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 12-5-1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Montgomery City, Missouri
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Francis Mc Quoid	
13b. MOTHER'S MAIDEN NAME Mary Quentin		14. NAME OF HUSBAND OR WIFE John W. Leach	
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'S SIGNATURE OR NAME Philip Leach		ADDRESS 5823 Theodore Ave.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease with congestive failure		INTERVAL BETWEEN ONSET AND DEATH 3 months	
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.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? H200			
22. I hereby certify that I attended the deceased from Feb. 23, 1952 , to March 25, 1952 , that I last saw the deceased alive on March 25, 1952 , and that death occurred at 3:10 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE Clarence G. Mueller (Degree or title) M.D.		23b. ADDRESS 634 N. Grand Blvd.	
23c. DATE SIGNED 3-26-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 3-28-52	
24c. NAME OF CEMETERY OR CREMATORY Memorial Park		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
DATE REC'D BY LOCAL REG. MAR 26 1952		REGISTRAR'S SIGNATURE Carl Smith	
25. FUNERAL DIRECTOR'S SIGNATURE Drehmann-Harral		ADDRESS 1905 Union Blvd.	

(Licensed Embalmer's Statement on Reverse Side)

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

3. No. 300
v. 10.48

FILED APR 12 1952

Dr. C. E. Mueller
Mo. Theatre Bldg.

(2-4)

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 Albert R. Thompson

Licensed Embalmer No. 42137

P. O. Address St. Louis

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.