

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40314**
Registrar's No. **10284**

FILED NOV 19 1953

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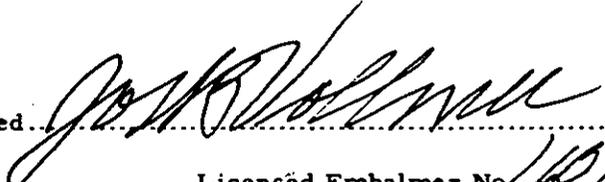
BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. 10284	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital				e. STREET ADDRESS (If rural, give location) 1834a So. 10th St			
3. NAME OF DECEASED (Type or Print) a. (First) LEONARD b. (Middle) B c. (Last) COOMBS			4. DATE OF DEATH (Month) (Day) (Year) OCTOBER 27, 1953				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Oct 5 1865	
9. AGE (In years last birthday) 88		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) Miner			10b. KIND OF BUSINESS OR INDUSTRY Coal		11. BIRTHPLACE (City and State or Foreign Country) Kentucky /		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Leonard Coombs			13b. MOTHER'S MAIDEN NAME Jane Sutton		14. NAME OF HUSBAND OR WIFE Pairlee Coombs		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Juanita Gibbons 1943 Northfield			
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) Chronic subdural hematoma Cystic degeneration 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
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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) _____			
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? 223X			
22. I hereby certify that I attended the deceased from 9-22-53 , 19____, to 10-27-53 , 19____, that I last saw the deceased alive on 10-27-53 , 19____, and that death occurred at 3:50A m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) J. K. Citterlusch M.D.				23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 10-27-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Oct 30 53		24c. NAME OF CEMETERY OR CREMATORY Calvary		24d. LOCATION (City, town, or county) (State) St. Louis Mo	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE OCT 29 1953		REGISTRAR'S SIGNATURE Earl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E.J. Schnur 3125 Lafayette			

WRITE PLAINLY—USING 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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....


Licensed Embalmer No.....
10/13

P. O. Address.....
3125 Delaware

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.