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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 6399

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1483

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: 915 N.GRAND,ST.LOUIS,MO. — Inside Limits: Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: VA HOSPITAL — Length of stay in Ib: 16 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: FRANKLIN
c. CITY OR TOWN: SULLIVAN 0360 — Inside Limits: Yes ☐ No X
d. STREET ADDRESS (If outside, give location): ROUTE #2 — Reside on Farm: Yes X No ☐

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3. NAME OF DECEASED (Type or print): First: JAMES Middle: H. Last: LEATH

4. DATE OF DEATH Month Day Year: FEBRUARY 12, 1957

5. SEX: MALE **6. COLOR OR RACE:** WHITE **7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐ **8. DATE OF BIRTH:** 7/16/90 **9. AGE** (In years last birthday): 66 — 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): UNKNOWN **10b. KIND OF BUSINESS OR INDUSTRY:** — **11. BIRTHPLACE** (City and state or country): VALLEY PARK, MO. **12. CITIZEN OF WHAT COUNTRY?** USA

13. FATHER'S NAME: ALFRED H. LEATH **14. MOTHER'S MAIDEN NAME:** EMMA JANE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW-1 **16. SOCIAL SECURITY NO.:** 490-28-6014 **17. INFORMANT** Address: VA HOSP. RECORDS, ST. LOUIS, MO.

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) MASSIVE CEREBRAL HEMORRHAGE AND INFARCTION (LEFT SIDE) — INTERVAL BETWEEN ONSET AND DEATH: Within 1 month
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES X NO ☐ /

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 ☐ VA **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 1/27/57, to 2/12/57 and last saw ~~XXX~~ him alive on 2/12/57
Death occurred at 3:45 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Hy. E. Westphalinger **(Degree or title)** **22b. ADDRESS** 915 N.Grand VAH, ST. LOUIS, MO. **22c. DATE SIGNED** 2/12/57

23a. BURIAL, CREMATION, REMOVAL (Specify): removal **23b. DATE:** 2-15-57 **23c. NAME OF CEMETERY OR CREMATORY:** National Cemetery **23d. LOCATION** (City, town, or county) (State): Jefferson Barracks, Mo.

24. FUNERAL DIRECTOR Edward Fendler Mortuary **ADDRESS** 5611 S.Grand **25. DATE RECD. BY LOCAL REG.** FEB 13 '57 **26. REGISTRAR'S SIGNATURE** J. Carl Smith MD MKB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Harry J. Schum

Licensed Embalmer No. 26

P. O. Address 6611 S.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.