

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED NOV 1 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

37755
STATE FILE NUMBER
9901

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MARIAN HOSPITAL</u>			Length of stay in lb		d. STREET ADDRESS (If outside, give location) <u>214 2121 CRITTENDEN</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MAUDE</u> Middle <u>C</u> Last <u>LEUSCHKE</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>20</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 1 1897</u>		9. AGE (In years last birthday) <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>	
13. FATHER'S NAME <u>WILLIAM COWIE</u>				14. MOTHER'S MAIDEN NAME <u>SARAH L COLUMBUS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>ERNEST LEUSCHKE 2121 CRITTENDEN</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DISEASE WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Paralytic stroke,</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertension</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 day more than 2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <u>Diabetes Mellitus, Dermatitis Factitia, 334X</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			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. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>Oct 6, 1941</u> to <u>Oct 20, 1957</u> and last saw her ^{alive} on <u>Oct 19, 1957</u> Death occurred at <u>12:20 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Leroy E. Ellison MD</u>				22b. ADDRESS <u>3610 90 Broadway St Louis Mo</u>		22c. DATE SIGNED <u>Oct 21, 1957</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>OCT 23 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LAKE CHARLES CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY, MO</u>		
24. FUNERAL DIRECTOR <u>Thomas Kutis 2906 Gravois</u>		ADDRESS		25. DATE RECD. BY LOCAL REG. <u>OCT 23 '57</u>		26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>	

M. E. O.

36105
PR 6-4683
11-4
Hickory

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 *Samuel C. Hill*

Licensed Embalmer No. *434*

P. O. Address *2906*

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.