

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010832
STATE FILE NUMBER
2 1678

MAR 18 1959

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

300
1-57

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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY <i>L. James</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN JENNINGS <i>4138</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION CHRISTIAN HOSPITAL		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 1814 COLERIDGE
3. NAME OF DECEASED (Type or print) First Middle Last LEO FRANCIS CURRY			4. DATE OF DEATH Month Day Year FEB. 15, 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 2, 1909
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY AUTO PARTS DEPT.	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME MICHAEL CURRY	13b. MOTHER'S MAIDEN NAME NORA FORD
14. NAME OF HUSBAND OR WIFE NONE		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.
17. INFORMANT ESTELLE BUB 1814 COLERIDGE, JENNINGS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Laemnes & Cirrhosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) <i>581.1</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Esophageal Varices & Hepatic Coma</i>			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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20e. CITY, TOWN, OR LOCATION	COUNTY	STATE	
21. I attended the deceased from <i>Jan 12, 1959</i> to <i>Feb 15, 1959</i> and last saw her alive on <i>Feb 14, 1959</i> Death occurred at <i>10:10 am</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Lyvester A. Felitti M.D.</i>		22b. ADDRESS <i>8700 Rivermiss Blvd</i>	22c. DATE SIGNED <i>2/16/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
BURIAL	FEB. 18, 1959	CALVARY CEMETERY	ST. LOUIS, MO.
24. FUNERAL DIRECTOR STROOT CARROLL 4600 NATURAL BRIDGE		25. DATE RECD. BY LOCAL REG. FEB 17 '59	26. REGISTRAR'S SIGNATURE <i>Carl Smith. M.D.</i>

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 *M W Ruster*

Licensed Embalmer No. *4865*

P. O. Address *St Louis, Mo*

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.