

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019318

STATE FILE NUMBER

Registration No. **24616**

FILED MAY 22 1959

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DePaul Hospital</b>			Length of stay in lb. <b>7 days</b>	d. STREET ADDRESS (If outside, give location) <b>6177 Washington</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mildred</b> Middle <b>Leach</b> Last <b>Kelly</b>				4. DATE OF DEATH Month <b>May</b> Day <b>10th</b> Year <b>1959</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 11th. 1898</b>		9. AGE (In years last birthday) <b>61</b>	10. UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Apartment Manager Winston Churchill</b>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Robert Leach</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Cody</b>		14. NAME OF HUSBAND OR WIFE <b>Joseph Kelly</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no no</b>			16. SOCIAL SECURITY NO. <b>499-20-9042</b>	17. INFORMANT Address <b>Joseph Kelly 6177 Washington</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatous process in Cervix Uteri</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Obstruction caused by Ca.</b>							
DUE TO (c) <b>171x</b>							
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 <input type="checkbox"/> NO <input checked="" 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 <b>3.30</b> Month, Day, Year <b>5/10/59</b> 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 <b>12/16/58</b> to <b>5/10/59</b> and last saw her alive on <b>5/10/59</b> . Death occurred at <b>5/10/59</b> <b>3.30</b> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>George A. Canale M.D.</b>				22b. ADDRESS <b>607 N. Grand</b>		22c. DATE SIGNED <b>5/11/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>5-13-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Arthur J. Donnelly 3840 Lindell Blvd.</b>			25. DATE RECD. BY LOCAL REG. <b>MAY 12 '59</b>		26. REGISTRAR'S SIGNATURE <b>Loard Smith. M.D.</b>		

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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. 4699

P. O. Address 3840 Lund

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.