

# R I DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026876

**FILED VS AUG 5 1959**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 6817** STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Length of stay in 1b <b>10 Years</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____  c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <b>1334 Blackstone Ave</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Christian Hospital.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1334 Blackstone Ave</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <b>Irene</b> Middle <b>Jane</b> Last <b>Leake</b>	<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>20</b> Year <b>1959</b>
---	---

<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>1-6-87</b>	<b>9. AGE (last birthday)</b> <b>72</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
--------------------------------	---	---	--	--	--	--

<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Domestic</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Housework</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Chicago, Ill.</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>
---	--	---	---

<b>13a. FATHER'S NAME</b> <b>Robert Benson</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Mary Benson</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Harry G. Dcd.</b>
---	--	--

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	<b>16. SOCIAL SECURITY NO.</b> <b>490-36-3178</b>	<b>17. INFORMANT</b> Address <b>Josephine Johnson 2217-Hood Ave</b>
--	--	--

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease,</b> <b>congestive failure</b> DUE TO (b) _____ DUE TO (c) _____ (Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)	INTERVAL BETWEEN ONSET AND DEATH - ?
---	---

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a)	<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
--	---

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
--	--	---

<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.	Month, Day, Year _____
--	------------------------

<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE
--	---	--

<b>21. I attended the deceased from</b> <b>July 20, 1959</b> to <b>July 20, 1959</b> and last saw her <b>alive on</b> <b>July 20, 1959</b> Death occurred at <b>12:15 P</b> on the date stated above, and to the best of my knowledge, from the causes stated
--

<b>22a. SIGNATURE</b> (Deduce or title) <b>John E. McJannet MD</b>	<b>22b. ADDRESS</b> <b>5014 Sheila Av</b>	<b>22c. DATE SIGNED</b> <b>7/22/59</b>
---	--	---

<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE</b> <b>7-23-1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Calvary Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis, Mo.</b>
---	--------------------------------------	--	---

<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Baumann Bros - Inc</b> <b>2504 Woodson Rd - Overland-14 - Mo.</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>JUL 22 '59</b>	<b>26. REGISTRAR'S SIGNATURE</b> <b>Loal Smith, M.D.</b> mrs B
--	--	--

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed David C. Gibson

Licensed Embalmer No. 3454

P. O. Address Portland

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.