

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026878

FILED VS AUG 13 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7151**

| | | | |
|---|-------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY ST. LOUIS | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SAINT LOUIS | Length of stay in 1b 3 1/2 weeks | c. CITY OR TOWN BEL*RIDGE | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION MISSOURI BAPTIST HOSPITAL | | d. STREET ADDRESS (If outside, give location) 3137 THELMA AVENUE | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | | |
|---|---------------------------|---|--|--|---|
| 3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM P. LEGGE | | | 4. DATE OF DEATH Month Day Year JULY 31 1959 | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 11/20/97 | 9. AGE (last birthday) 61 years | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGRAVER | | 10b. KIND OF BUSINESS OR INDUSTRY PHOTO | 11. BIRTHPLACE (City and state of country) TORONTO, CANADA | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME WILLIAM H. LEGGE | | 13b. MOTHER'S MAIDEN NAME ESTHER COX | | 14. NAME OF HUSBAND OR WIFE VELMA (SMITH) LEGGE | |
| 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. UNKNOWN | 17. INFORMANT Address MRS. VELMA LEGGE, 3137 THELMA AVE (21) | | |

| | | |
|---|------------|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute monocytic leukemia</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) | |
| | DUE TO (c) | <u>204.2</u> |

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

| | | | |
|---|---|--|--|
| 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. | Month, Day, Year | | |

| | | | | |
|--|--|------------------------------|--------|-------|
| 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 April 1959 to July 31, 1959 and last saw ^{her}him alive on July 31, 1959
Death occurred at 7:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | | |
|--|----------------------------|---|---|--|
| 22a. SIGNATURE <u>John L. Horner</u> | | (Degree or title) <u>M.D.</u> | 22b. ADDRESS <u>114 W. Taylor, St. Louis 8</u> | 22c. DATE SIGNED <u>8-1-59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE <u>8/3/59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEMETERY</u> | 23d. LOCATION (City, town, or county) <u>ST. LOUIS COUNTY, MISSOURI.</u> | |
| 24. FUNERAL DIRECTOR <u>CALVIN F. FEUTZ, 4828 NAT'L. BRIDGE BLVD.</u> | | ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>AUG 3 '59</u> | 26. REGISTRAR'S SIGNATURE <u>Loan Smith, M.D.</u> |

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 John A. Nelson

Licensed Embalmer No. 4184

P. O. Address St. Louis

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.