

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028665

FILED VS AUG 31 1959

Registration District No. 225-116 Primary Registration District No. 5434 Registrar's No. 180

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Franklin</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St John's Township</u>		Length of stay in lb <u>26 yrs</u>		c. CITY OR TOWN <u>St John's Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RR #1 East Washington</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>RR #1 East Washington</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>SOPHIE</u> Middle <u>LEV</u> Last <u>LEY</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>24</u> Year <u>1959</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>11-1-1907</u>		9. AGE (last birthday) <u>51</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			11. BIRTHPLACE (City and state or country) <u>Gildehaus, Mo</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				
13a. FATHER'S NAME <u>Martin Hellmann</u>				13b. MOTHER'S MAIDEN NAME <u>Anna Straatmann</u>				14. NAME OF HUSBAND OR WIFE <u>Henry J. Ley</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Henry J. Ley</u> Address <u>Washington, Mo</u>							
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>Coronary Dilatation</u> DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>4.6 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								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 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 _____ 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 <u>1940</u> to <u>8-24-59</u> and last saw <u>her</u> alive on <u>8-20-59</u> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>H. M. Smith</u> (Degree of _____)				22b. ADDRESS <u>Washington, Mo</u>				22c. DATE SIGNED <u>8-24-59</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Aug 27, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St John's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>RFD. V116 Ridge Mo</u>							
24. FUNERAL DIRECTOR <u>Nieborg & Vitt, Inc</u> ADDRESS <u>Washington Mo</u>				25. DATE RECD. BY LOCAL REG. <u>8-27-59</u>		26. REGISTRAR'S SIGNATURE <u>H. M. Smith</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 17 1969

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

Jerome F. Swoboda

Licensed Embalmer No. 4507

P. O. Address

Washington

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.