

# JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-034033

STATE FILE NUMBER

FILED OCT 13 1959

Primary Registration District No.

Registrar's **2 9025**

ENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Greene</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Length of stay in 1b <b>2 yrs. 2 Mo</b> <b>22 days</b>		c. CITY OR TOWN <b>Springfield, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis State Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1250 East Elm St.</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CLYDE</b>				First Middle Last <b>LESLIE</b>		4. DATE OF DEATH Month Day Year <b>Sept. 30, 1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>2-5-1888</b>	9. AGE (last birthday) <b>71 yrs</b>	IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>formerly: Salesman</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Newark, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>		
13a. FATHER'S NAME <b>Oren Leslie</b>			13b. MOTHER'S MAIDEN NAME <b>Henrietta (Gilhausen)</b>			14. NAME OF HUSBAND OR WIFE <b>Jeannett Leslie</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>Mrs. Darrell Robirston, 5616 Pershing Ave.</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>Acute coronary thrombosis with infarction, left.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Acute pulmonary embolism, rt. lung</b> DUE TO (c) <b>Old encephalomalacia, temporal and frontal</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>420.1</b>						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 <b>July 8, 1957</b> to <b>Sept. 30, 1959</b> and last saw <sup>her</sup> him alive on <b>Sept. 30, 1959</b> Death occurred at <b>L.N. McCullough, M.D.</b> <b>6:30 A.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>L.N. McCullough, M.D.</b>				22b. ADDRESS <b>5400 Arsenal St.</b>				22c. DATE SIGNED <b>9-30-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/2/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>			23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Arthur J. Donnelly, 3840 Lindell Blvd.</b>			25. DATE RECD. BY LOCAL REG. <b>OCT 1 '59</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>				

*M. S. B.*

DOCUMENT

MEDICAL CERTIFICATION

AFFIDAVIT OF

VS OCT 14 1959

**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 3111 Lumbert

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.