

URU DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034060

FILED OCT 13 1959

2 8805

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b	c. CITY OR TOWN Allenton Mo.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony Hosp.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) R.R. 1 Box 254

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First	Middle	Last	Month	Day	Year	
Leslie	John	Mc Dowell	Sept.	23	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 8-31-1910	9. AGE (last birthday) 49	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) Caretaker	10b. KIND OF BUSINESS OR INDUSTRY Childrens Camp	11. BIRTHPLACE (City and state or country) St. Louis Mo	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	---	--	---------------------------------------

13a. FATHER'S NAME John Mc Dowell	13b. MOTHER'S MAIDEN NAME Kate Bradley	14. NAME OF HUSBAND OR WIFE Noel Coad
--------------------------------------	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War 2	16. SOCIAL SECURITY NO. 489-14-6494	17. INFORMANT Noel Mc Dowell	Address R.R.1 Box 254
---	--	---------------------------------	--------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	arterio-sclerotic heart disease with coronary occlusion	1 day
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Bronchial asthma with pulmonary edema	2 yrs.
	DUE TO (c) old healed fibrotic pulmonary	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Chronic tuberculous disease of left kidney No morbidities. External & Internal Surgery (9/1/59)		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 Death occurred at	Sept. 10 - 59	to	Sept. 23, 59	and last saw him alive on	Sept. 22, 59
---	---------------	----	--------------	---------------------------	--------------

22a. SIGNATURE (Degree or title) George A. O'Sullivan M.D.	22b. ADDRESS 7629 Gray Ave.	22c. DATE SIGNED 9-24-59
---	--------------------------------	-----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-25-1959	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Missouri
--	------------------------	---	---

24. FUNERAL DIRECTOR Wingbermuehle	ADDRESS 3819 S. Grand Blvd	25. DATE RECD. BY LOCAL REG. SEP 24 59	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
---------------------------------------	-------------------------------	---	---

UNDECEASED  
 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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Geo. J. Hingermuehle*

Licensed Embalmer No. 4611

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.