

**FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-037324**

FILED VS OCT 27 1959

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 407 STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Francois</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre</u>	Length of stay in 1b	c. CITY OR TOWN <u>Bonne Terre</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bonne Terre Hosp</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>115 Jackson</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Maude</u> Middle <u>Ellen</u> Last <u>Leighton</u>	4. DATE OF DEATH Month <u>Oct</u> Day <u>19</u> Year <u>1959</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/30/85</u>	9. AGE (last birthday) <u>73</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Wisconsin</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Miles Dakins Kay</u>	13b. MOTHER'S MAIDEN NAME <u>Weltha Ann Crane</u>	14. NAME OF HUSBAND OR WIFE <u>Harold Leighton</u>
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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>554 42 6767</u>	17. INFORMANT <u>Fred Bullock</u> Address <u>3964 Lafayette</u>
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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>Cerebral thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Chronic hypertension</u>		Sev. yrs.
	DUE TO (c)		
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 10-18-59 to 10-19-59 and last saw her/him alive on 10-19-59  
Death occurred at 11:25 P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Wm A. Taylor</u>	22b. ADDRESS <u>Bonne Terre, Missouri</u>	22c. DATE SIGNED <u>10-21-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10/22/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul Churchyard</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis City Mo</u>
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24. FUNERAL DIRECTOR <u>E. J. Schnur</u> ADDRESS <u>3125 Lafayette, St. Louis, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Oct. 21, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Catherine Kudloff</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

OCT 30 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 \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Thomas R. Fenwick*

Licensed Embalmer No. 3793

P. O. Address 3125 Lafayette

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.