

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 5 6 6 6

FILED VS. JAN - 8 1960

211708

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) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in 1b	c. CITY OR TOWN ST. LOUIS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BETHESDA HOSPITAL		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2609 SO. Grand Blvd
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First JAMES Middle H. Last LEATHERS.			4. DATE OF DEATH Month Dec. Day 16, Year 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 10-13-1872	9. AGE (last birthday) 87	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) Retired		10b. KIND OF BUSINESS OR INDUSTRY Franklin Co., Mo.		11. BIRTHPLACE (City and state or country) U.S.A.		
13a. FATHER'S NAME James H. Leathers		13b. MOTHER'S MAIDEN NAME Lucinda Reed		14. NAME OF HUSBAND OR WIFE Anna Nelson Leathers		
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. 498-01-9836A		17. INFORMANT Address Memorial Home 2609 S. Grand Blvd.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Ribs DUE TO (b) Arterio sclerotic Heart Disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		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) Suffered in fall		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 checked="" 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.) Slipped on steps at Memorial Home on or about December 9, 1959.	
20c. TIME OF INJURY Hour _____ s.m. _____ p.m. Month, Day, Year 11 299 1959	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	20f. CITY, TOWN, OR LOCATION St. Louis Mo

21. I attended the deceased from _____ and last saw her/him alive on _____ Death occurred at 8:50 P. m on the date stated above, and to the best of my knowledge, from the causes stated.	
---	--

22a. SIGNATURE (Degree or title) Joseph M. Lupton	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 12/17/59
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Removal	23b. DATE 12-19-59	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery
24. FUNERAL DIRECTOR ADDRESS C.R. Lupton & Sons; 7233 Delmar Blvd		23d. LOCATION (City, town, or county) St. Louis Co., Mo.

25. DATE RECD. BY LOCAL REG. DEC 17 1959	26. REGISTRAR'S SIGNATURE Roal Smith, M.D.
--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

m 8 B

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 Clarence H. Mu

Licensed Embalmer No. 4011

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.