ORI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JAN - 4 1960

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STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 3437

NDED

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Hgts.
Length of stay in 1b HRS.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital
Inside Limits Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis
c. CITY OR TOWN Richmond Hgts. 17,
Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) 6348 Clayton Rd.
Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First THOMAS Middle A. Last LEACH
4. DATE OF DEATH Month Dec. Day 22, Year 1959
5. SEX F
6. COLOR OR RACE W
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH Oct. 17, 1877
9. AGE (last birthday) 82
IF UNDER 1 YEAR Months 2 Days 5 IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Meat Cutter
10b. KIND OF BUSINESS OR INDUSTRY Self Employed
11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY U. S. A.
13a. FATHER'S NAME William Leach
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Selina Leach
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 488-07-4091
17. INFORMANT Selina Leach Address 6348 Clayton Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH 7yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Coronary Arteriosclerosis — 7yrs
DUE TO (c) Pulmonary Emphysema — Unk.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I(a) Chronic Brain Syndrome
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Dec 21, to Dec 21 and last saw her/him alive on Dec 22
Death occurred at 6:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Daniel E. Beckman M.D.
22b. ADDRESS 4205 Virginia Ave
22c. DATE SIGNED 12/28/59

23a. BURIAL, CREMATION, REMOVAL Burial
23b. DATE Dec. 24, 1959
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
23d. LOCATION (City, town, or county) St. Louis, Mo. (State)

24. FUNERAL DIRECTOR A. H. Bocklage F. H. ADDRESS 6536 Clayton, Rd.
25. DATE RECD. BY LOCAL REG. 12-24-59
26. REGISTRAR'S SIGNATURE John E. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Jam Bunbiley

Licensed Embalmer No. 3653

P. O. Address St Lew

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