

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

FILED VS JUL 7 1960

318

1003

6243

60-024707  
STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>St. Clair,</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Louis MO</b>		c. CITY OR TOWN <b>E. St. Louis,</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Fitzsim Dosloye Hosp</b>		d. STREET ADDRESS (If outside, give location) <b>1475 Ohio</b>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Charles</b> Last <b>Leepy</b>		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>60</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3-12-20</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Orider Trucking Company</b>	
11. BIRTHPLACE (City and state or country) <b>E. St. Louis, Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Clyde Leepy</b>		13b. MOTHER'S MAIDEN NAME <b>Cecelia</b>	
14. NAME OF HUSBAND OR WIFE <b>Helen Leepy</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>332-12-9444</b>		17. INFORMANT <b>Helen Leepy 1475 Ohio-E. St. Louis</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>Left Heart Failure</b> DUE TO (b) <b>Aortic Stenosis</b> DUE TO (c) <b>Rheumatic Heart Dispass</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>Ill.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>411x</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 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 Month, Day, Year a.m. p.m.			
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>June 1, 1960</b> to <b>June 17, 1960</b> and last saw her/him alive on <b>June 16, 1960</b> Death occurred at <b>6:30 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Bernard L. Hoover MD</b>		22b. ADDRESS <b>5463 Delmar Apt 219</b>	
22c. DATE SIGNED <b>6-17-60</b>		23. LOCATION (City, town, or county) (State) <b>Belleville, Ill.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>6-20-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Hope Cemetery</b>	
24. FUNERAL DIRECTOR <b>Joseph J. Kassly</b>		25. DATE RECD. BY LOCAL REG. <b>June 18, 1960</b>	
ADDRESS <b>E. St. Louis, Ill.</b>		26. REGISTRAR'S SIGNATURE <b>Roan Smith. M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

