

UNIVERSITY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-025183

FILED VS JUN 20 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 1706

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>ST LOUIS</u>	a. STATE <u>MO.</u> b. COUNTY <u>ST LOUIS</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WEBSTER GROVES</u>	Length of stay in 1b <u>2 YRS</u>	c. CITY OR TOWN <u>ST LOUIS Co.</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>GLENWOOD HOSP.</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>19 BELLERIVE ACRES</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First <u>JEFFERSON</u>	Middle <u>C.</u>	Last <u>LEACH</u>	Month <u>5</u>	Day <u>30</u>	Year <u>1960</u>	

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/13/1882</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR	IF UNDER 24 HR
				Months	Days	Hours

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LUMBER MAN</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>BLDG.</u>	11. BIRTHPLACE (City and state or country) <u>MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>MARCUS LEACH</u>	13b. MOTHER'S MAIDEN NAME <u>SARAH HOPE</u>	14. NAME OF HUSBAND OR WIFE <u>CORA LEACH</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>RAYMOND LEACH #19 BELLERIVE ACRES</u>	Address
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>LOBAR - PNEUMONIA</u>		
Conditions, if any, which gave rise to above cause (a), starting the underlying cause last.	DUE TO (b) <u>cerebral arteriosclerosis</u>	
	DUE TO (c) <u>generalized arteriosclerosis</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Senile psychosis</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> p.m. <u>—</u>	Month, Day, Year
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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.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from APR. 23, 1959 to 5-30-60 and last saw him alive on 5-30-60  
 Death occurred at 1 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Deceased or title) <u>Thomas T. Flynn</u>	22b. ADDRESS <u>ST LOUIS, MO</u>	22c. DATE SIGNED <u>5-31-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>6-1-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PK.</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Co. MO</u>
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24. FUNERAL DIRECTOR <u>BUCHHOE Z MORT.</u>	ADDRESS <u>5967 W. FLORISSANT</u>	25. DATE RECD. BY LOCAL REG. <u>5-31-60</u>	26. REGISTRAR'S SIGNATURE <u>J. G. Murphy M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FORMS - EMBALMERS

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

*Gustav W. Puterbaugh*

Licensed Embalmer No. 4329

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.