

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS NOV 28 1960

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-60-043842

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **10869** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. 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		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3500 Miami		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First LETITIA Middle B. Last LAURIE			4. DATE OF DEATH Month Nov. Day 9 Year 1960						
5. SEX Female	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 7-7-1886	9. AGE (last birthday) 74		IF UNDER 1 YEAR Months _____ Days _____ Hours _____		IF UNDER 24 HR Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13a. FATHER'S NAME William Leahey			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Peter Laurie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 489-05-9217B		17. INFORMANT Address Peter Laurie 3500 Miami					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of right hip; Generalized Arteriosclerosis; suffered in fall to floor of living room at home on or about Oct. 25, 1960							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)		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			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Accident									
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.) 904-0-21							
20c. TIME OF INJURY Hour _____ s.m. _____ p.m. 10 25 60		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.) 16 home - living room		20f. CITY, TOWN, OR LOCATION St. Louis		20g. COUNTY Mo.	20h. STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 2:55 P. M. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>Edna E. Doyle</i> (Degree or title)				22b. ADDRESS 1300 Olive		22c. DATE SIGNED 11/10/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE Nov. 12, 1960		23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Mausoleum		23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.			
24. FUNERAL DIRECTOR ADDRESS Kriegshausen 4228 S. Kingshighway Blvd.				25. DATE RECD. BY LOCAL REG. NOV 10 1960		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>			

DOCUMENT

MEDICAL CERTIFICATION

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 _____, Student Embalmer No. _____

or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Edurn A. M. Acosta

Licensed Embalmer No. 3024

P. O. Address _____

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.