

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048344

FILED VS JAN 5 1961 317 500 3794  
 Registration District No. Primary Registration District No. Registrar's No. STATE FILE NUMBER

DED  
DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Lemay</b>		Length of stay in 1b <b>10 years</b>	c. CITY OR TOWN <b>Lemay</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>154 E. Etta</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>154 E. Etta</b>

3. NAME OF DECEASED (Type or print) First <b>Evan</b> Middle <b>Dale</b> Last <b>Leach</b>			4. DATE OF DEATH Month <b>December</b> Day <b>29</b> Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</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>7/7/1911</b>	9. AGE (last birthday) <b>49</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cooper</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>St. Louis Flour Mill</b>	11. BIRTHPLACE (City and state or country) <b>Hanson, Illinois</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>James Leach</b>		13b. MOTHER'S MAIDEN NAME <b>Lillian Cowgill</b>		14. NAME OF HUSBAND OR WIFE <b>Evelyn Waddington Leach</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes Peacetime</b>		16. SOCIAL SECURITY NO. <b>486 22 7733</b>	17. INFORMANT <b>Evelyn Leach 154 E. Etta, Lemay, Mo.</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>Carcinoma of Lung</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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	
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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.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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

21. I attended the deceased from **1958** to **Dec. 29, 1960** and last saw her alive on **Nov. 29, 1960**  
 Death occurred at **12:40 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Olman J. Sullivan M.D.</b>		22b. ADDRESS <b>4161 Lindell St. Louis, Mo.</b>		22c. DATE SIGNED <b>12-30-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 31, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Lemay, Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>C. Hoffmeister Mortuaries 7814 S. Broadway St. Louis, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>12-31-60</b>	26. REGISTRAR'S SIGNATURE <b>John G. Murphy M.D.</b>	

Dr. Clement Sullivan OL 2-1917  
4161 Lindell 1-30 PM - 6 PM  
2-6 PM Friday

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John J. [Signature]

Licensed Embalmer No. 91

P. O. Address St. Louis

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