

FILED JAN 15 1956

## STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

11793

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1317 Kraft Ave</b>		Length of stay in lb <b>4 yrs. 2049</b>		d. STREET ADDRESS <b>1317 Kraft Ave.</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Leland</b> Middle <b>F.</b> Last <b>Cottin</b>			4. DATE OF DEATH Month <b>Dec.</b> Day <b>22</b> Year <b>1956</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>May 11 1895</b>		9. AGE (In years last birthday) <b>61</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Warehouse Packer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Famous-Barr Co.</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>N (Unknown) Cottin</b>				14. MOTHER'S MAIDEN NAME <b>Florence Spar</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W. I</b>		16. SOCIAL SECURITY NO. <b>193-10-0268</b>		17. INFORMANT Address <b>Theresa Jane Cottin 1317 Kraft</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>Myocarditis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>History 7-8 yrs.</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) <b>Recent upper respiratory disease</b>							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.) <b>422.2</b>				
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>11-27-56</b> , to <b>12-17-56</b> and last saw <sup>him</sup> alive on <b>12/13/56</b> Death occurred at <b>8:30 P</b> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Thm. G. Reed M.D.</b> (Degree or title)				22b. ADDRESS <b>1019 McCausland St. Rain</b>		22c. DATE SIGNED <b>12-24-56</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Dec. 26 1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>		23d. LOCATION (City, town, or county) <b>Jeff. Bks.</b>		(State) <b>Mo.</b>
24. FUNERAL DIRECTOR <b>Holmeister Colonial Mortuary</b> ADDRESS <b>6264 Chippewa St., St. Louis, MO.</b>				25. DATE RECD. BY LOCAL REG. <b>DEC 24 1956</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b> <b>mgb</b>	

(Licensed Embalmer's Statement on Reverse Side)

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All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ex-  
posed by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Bill C. Branson*.....

Licensed Embalmer No. *422*

P. O. Address *St. Louis*.....

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