

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5809 Walsh St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days)

8. (a) PRINT FULL NAME Ursula Schleicher

3. (b) If veteran, name war _____ 3. (c) Social Security No. No

4. Sex Female / 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Louis P. Schleicher 6. (c) Age of husband or wife If alive _____ years

7. Birth date of deceased Dec. 18 1866
(Month) (Day) (Year)

8. AGE: Years 81 Months 0 Days 28 If less than one day hr. _____ min. _____

9. Birthplace Switzerland
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Own home

MOTHER FATHER { 12. Name Peter Geiger 5

13. Birthplace Switzerland
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant P. W. Schleicher

(b) Address 5809 Walsh St.

17. (a) Cremation (b) Date thereof Jan 14 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director G. Hoffmeister Colonial Mortuary

(b) Address 6464 Chippewa St.

19. (a) JAN 12 1948 (b) J. F. Broderick
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5809 Walsh St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 11
year 1948 hour 9 minute 15 P.M.

21. I hereby certify that I attended the deceased from April 15 1941 to Jan 11 1948

that I last saw her alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis

Due to Chronic Hypertension

Due to Arteriosclerosis

Other conditions (Include pregnancy within 3 months of death) 1/2/1948

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

Signature [Signature] (M. D. or other) MD
Address 2844 Oak St Date signed 1/12/48

Duration 8 yrs
PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Baumgartner
2844a California Ave.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

Harry J. Schumacher

Licensed Embalmer No. *2679*

P. O. Address *7814 1/2 Broadway*

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 this body is not embalmed, above space should be left blank.