

**THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH**

State File No. **7485**  
Registrar's No. **3**

BIRTH NO. **FILED FEB 26 1954** REG. DIST. NO. **328 335** PRIMARY REG. DIST. NO. **4492**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>SCOTT</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> d. COUNTY <b>SCOTT</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ORAN</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ORAN</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ORAN</b>		d. STREET ADDRESS (If rural, give location) <b>ORAN</b>	

<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <b>LEO</b> b. (Middle) <b>SCHLITT</b> c. (Last) <b>SCHLITT</b>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>FEB. 18 1954</b>		
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>MARRIED</b>	<b>8. DATE OF BIRTH</b> <b>AUG. 30 1887</b>	<b>9. AGE</b> (In years last birthday) <b>66</b>	<b>IF UNDER 1 YEAR</b> Months Days Hours Mins.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>MISSOURI</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>					

<b>13a. FATHER'S NAME</b> <b>JOHN SCHLITT</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>LOUISE SCHOEN</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>CLARA ESSNER SCHLITT</b>	
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>	<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>CLARA ESSNER SCHLITT</b>			
		<b>ADDRESS</b> <b>ORAN, MO</b>			

<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <b>Fatal Scleroderma</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
	<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Progressive polyarteritis</b>		
	DUE TO (c) <b>none</b>		
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death. <b>none 293X</b>			

<b>19a. DATE OF OPERATION</b> <b>none</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>none</b>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
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<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify) <b>none</b>	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>none</b>	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> <b>none</b>
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <b>none</b> m.	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b> <b>none</b>

**22. I hereby certify that I attended the deceased from Feb 15, 1954, to Feb 18th, 1954, that I last saw the deceased alive on Feb 18, 1954, and that death occurred at 9:45P m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> (Degree or title) <b>Lucille D O 2</b>	<b>23b. ADDRESS</b> <b>Oran MO</b>	<b>23c. DATE SIGNED</b> <b>2-19-54</b>
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<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>	<b>24b. DATE</b> <b>FEB. 22 1954</b>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <b>NEW GUARDIAN ANGELS</b>	<b>24d. LOCATION</b> (City, town, or county) (State) <b>ORAN SCOTT MO.</b>
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<b>DATE REC'D BY LOCAL REG.</b> <b>2-23-54</b>	<b>REGISTRAR'S SIGNATURE</b> <b>Miss F. Bishop</b>	<b>445</b>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Carl Smith</b>	<b>ADDRESS</b> <b>ORAN, MO.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300  
10.48

RECEIVED  
SCOTT COUNTY HEALTH CENTER  
CO. FILE NO. 254-48

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Earl Smith

Licensed Embalmer No. 2676

P. O. Address Craw, Mo.

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, fact should be so stated above.