

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39209
State File No. 9842
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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, write RURAL and give township) OR TOWN ST. LOUIS	c. LENGTH OF STAY (In this place) 3 hrs	c. CITY OR TOWN ST LOUIS	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION. ST. LOUIS CITY HOSPITAL			
e. STREET ADDRESS (If rural, give location) 19 4129 Lindell Blvd 21910			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) EDWARD	b. (Middle)	c. (Last) SCHLEICHER	DEATH OCTOBER 28, 1954		

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Feb 11, 1870	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months 8 Days 17	IF UNDER 1 HRS. Hours 1 Min.
--------------------	-------------------------------	--	--------------------------------------	---	--	-------------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Church Artist		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Appleton Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
---	--	-----------------------------------	--	---	--	---	--

13a. FATHER'S NAME Frederick Schleicher		13b. MOTHER'S MAIDEN NAME Sophie Raphael		14. NAME OF HUSBAND OR WIFE Irene Schleicher	
---	--	--	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Antoine Frank, 4929 Lindell Blvd			
--	-------------------------------------	--	--	--	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured abdominal aortic dissecting aneurysm.		DUPLICATE			Undetermined	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Hypertensive Cardiovascular Disease & Arteriosclerosis. Heart Disease & old myoc. infarction				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
------------------------	----------------------------------	--	--	---	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 451-X
--	--	--

22. I hereby certify that I attended the deceased from **10-28-54, 19**, to **10-28-54, 19**, that I last saw the deceased alive on **10-28-54, 19**, and that death occurred at **12:25 PM.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joseph M. Johnston Jr MD		23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 10-29-54
---	--	--	-------------------------------------

24. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE Nov 1, 1954	24c. NAME OF CEMETERY OR CREMATORY ST. MATTHEWS CEMETERY	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
---	---------------------------------	--	--

DATE REC'D BY LOCAL REG. OCT 30 1954	REGISTRAR'S SIGNATURE J. Earl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bull Campbell, 5165 Delmore Blvd
--	--	---

(Licensed Embalmer's Statement on Reverse Side)

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

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.....
Signature of Student Embalmer

Signed *Rev. E. Campbell*.....

Licensed Embalmer No. 388

P. O. Address *W. Lewis St.*

**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.**