

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

NOV 16 1938

34158
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
 (b) Township Primary Registration District No. **1003**
 (c) City **St. Louis - Mo.** (d) Street No. **Turner Desloge Hospital** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Stillborn Leicht**

(a) Residence, No. **40499 Schiller Place** St. **15**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **MALE** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Stillborn**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **October - 20 - 1938**
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hr. or min.
none
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) **St. Louis**
 (STATE OR COUNTRY) **Missouri**

FATHER 13. NAME **Robert Leicht**
 14. BIRTHPLACE (CITY OR TOWN) **Rock Creek**
 (STATE OR COUNTRY) **Missouri**

MOTHER 15. MAIDEN NAME **Marie Young**
 16. BIRTHPLACE (CITY OR TOWN) **Valley Park**
 (STATE OR COUNTRY) **Missouri**

17. INFORMANT (ADDRESS) **Robert Leicht**
40499 Schiller Place

18. BURIAL, CREMATION, OR REMOVAL
Rock Creek Mo. DATE 10-21-38

19. FUNERAL DIRECTOR (NAME) **Berneth W. Galt**
 (ADDRESS) **Fenton Mo.**

20. FILED **OCT 21 1938**
J. J. Bredeck
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Oct. 20 1938**
 22. I HEREBY CERTIFY, That I attended **delivery** of **Stillborn Infant**, to 19.....
 First seen alive on To Death is said to have occurred on the date stated above, at **8:41 A. M.**
 The principal cause of death and related causes of importance were as follows:

Date of onset
Aplhyxia Neonatorum (PALLIDA)
 Other contributory causes of importance:
Congenital Stenosis Trachea (Partial)
Patent Ductus Arteriosus

Name of operation Date of
 What test confirmed diagnosis? Was there an autopsy? **Yes**.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
 Nature of injury

24. Was disease or injury in any way related to occupation of deceased? **No**
 If so, specify
 (Signed) **Bernard H. Gerwitz** M. D.
 (Address) **Metropolitan Bldg.**

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,

Herbert W Koch, or by

Registered Apprentice No....., working under my personal supervision.

Signed *Herbert W Koch*

Licensed Embalmer No. *30847*

P. O. Address *Herbert W Koch*

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.