No. 2
-13-40
17-39
X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33959

Registration District No. 791 FILED NOV 16 1940 Primary Registration District No. 1003 Registrar's No. 8656

1. PLACE OF DEATH:
(a) County St. Louis, Mo.
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution City Sanitarium 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16yrs.6mo.16days (Specify whether years, months or days)
In this community About 76 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis 13 ~~26~~ (If outside city or town limits, write "RURAL")
Street No. 1423 Mallinckrodt (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Anna Schlichtig
3. (b) If veteran, name war No
3. (c) Social Security No. Unknown
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Frank Schlichtig
6. (c) Age of husband or wife if alive 1859 years
7. Birth date of deceased Dec. 8th. (Month) (Day) (Year)
8. AGE: Years About 81yrs Months 10 Days 11 If less than one day hr. min.
9. Birthplace St. libory (City, town, or county) Illinois (State or foreign country) 1
10. Usual occupation Housework 1
11. Industry or business 6
MOTHER FATHER
12. Name Charles Kinshea 6
13. Birthplace Unknown (City, town, or county) Germany (State or foreign country)
MOTHER
14. Maiden name Anna Marie Lipkea
15. Birthplace Unknown (City, town, or county) Germany (State or foreign country)
16. (a) Informant L. Weggendorf
(b) Address 5400 Arsenal St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-1940 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary
18. (a) Signature of funeral director Arthur J. Donnelly
(b) Address 3840 Lindell Blvd.
19. (a) OCT 21 1940 (Date received local registrar) (b) J. F. Bickel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 19 year 1940 hour 7:20 minute P. M.
21. I hereby certify that I attended the deceased from 7-1-39, 19__, to 10-19-40, 19__; that I last saw her alive on 10-19-40, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Arteriosclerotic Heart Disease
O(onset 7-1-39x)
Due to Carcinoma of right ovary
with Metastases (onset 7-1-39x)
Due to Senility (Onset 7-1-39x)

Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy Yes.

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

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? (Specify type of place)
While at work? (e) Means of injury 1
23. Signature Robert H. Grove (M. D. or other) M.D.
Address 5400 Arsenal Date signed 10/20/40

(Licensed Embalmer's Statement on Reverse Side)

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 Stanley Marsh

Licensed Embalmer No. 2868

P. O. Address 3840 Linde

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.