S. No. 2
M—5-42
v. 5-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 10 1943

Registration District No. 184

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 111

State File No. 3465

Registrar's No. 205

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Richmond Heights
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Mary's Hospital O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 17

(c) City or town St. Louis 9
(If outside city or town limits, write "RURAL")

(d) Street No. 926A Hamilton Ave.
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country 1

3. (a) PRINT FULL NAME Robert Lee William Leifheit.

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male

5. Color or race white

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased 1 (Month) 24 (Day) 1943 (Year)

8. AGE: Years | Months | Days | If less than one day 10 hr. 30 min.

9. Birthplace Richmond Heights (City, town, or county) Mo (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name William Frank Leifheit
13. Birthplace Aurora, Ne (City, town, or county) Nebraska (State or foreign country)

MOTHER
14. Maiden name Lyne Dolores Mittleberger
15. Birthplace Davenport (City, town, or county) Iowa (State or foreign country)

16. (a) Informant William Frank Leifheit
(b) Address 926 A Hamilton

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 26/43. (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave.

19. (a) JAN 27 1943 (Date received local registrar) (b) C. D. McGann, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 25 year 1943 hour 8.00 minute A.M.

21. I hereby certify that I attended the deceased from 1-24, 1943 to 1-25, 1943 that I last saw him alive on 1-25, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Prematurity	
Due to ?	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 159
Of autopsy

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

23. Signature Peter J. Reilly (M. D. or other)
Address 6125 Bartmer Ave. Date signed 1/25/43

(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 Jas. W. Leach

(NO EMBALMING)

Licensed Embalmer No. 1661

P. O. Address 1125 Hodiamont Ave.,

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.