

FILED APR 20 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14968
Registrar's No. 3404

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO. 1003		Registrar's No. 3404	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2159			
d. FULL NAME OF HOSPITAL OR INSTITUTION JEWISH HOSPITAL				12. STREET ADDRESS (If rural, give location) 4019 1/2 GILES			
3. NAME OF DECEASED (Type or Print) a. (First) ROBERT b. (Middle) L. c. (Last) SCHLECHT			4. DATE OF DEATH (Month) (Day) (Year) APRIL 17 1950				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH APRIL 6 1873	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months Days	IF UNDER 12 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PACKER		10b. KIND OF BUSINESS OR INDUSTRY WOLFING GROCER		11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME HENRY SCHLECHT		13b. MOTHER'S MAIDEN NAME CAROLINE SCHNEIDER		14. NAME OF HUSBAND OR WIFE BARBARA SCHLECHT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS BARBARA SCHLECHT 4019 1/2 GILES			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) cerebral arteriosclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 5+ weeks	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input 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) 332 X			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR			
22. I hereby certify that I attended the deceased from April 8, 1950, to April 12, 1950, that I last saw the deceased alive on April 11, 1950, and that death occurred at 1:20 A.M., from the causes and on the date stated above.							
23a. SIGNATURE Frank Cohen (Degree or title) M.D.				23b. ADDRESS 2330 1/2 UNION. ST. LOUIS MO		23c. DATE SIGNED April 17/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE APRIL 14 1950	24c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL PK.		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO		
DATE REC'D BY LOCAL REG. APR 12 1950		REGISTRAR'S SIGNATURE J. B. Sauter		25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis		ADDRESS 2916 Marrio	

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

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13301
2/1/2000

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 James C. Dill

Licensed Embalmer No. 4347

P. O. Address 2906 Lane's

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.