

FILED JUN 3 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

18380

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4596

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY	
b. CITY OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>City Hospital</u>		STREET ADDRESS (If rural, give location) <u>2735 Hickory</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Martin</u> b. (Middle) <u>Leichenauer</u> c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) <u>May 22 1950</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	
8. DATE OF BIRTH <u>Nov. 25 1890</u>			9. AGE (In years last birthday) <u>59</u>		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					

13a. FATHER'S NAME <u>Martin Leichenauer</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Idabell Leichenauer</u>	
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.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Idabell Leichenauer 2735 Hickory</u>	

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)		<u>Chronic decompensated myocarditis; Cirrhosis of liver; Interstitial nephritis</u>			
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>5973 X</u>	

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:55 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Cathel E Taylor MD</u>		23b. ADDRESS <u>1300 Clark</u>		23c. DATE SIGNED <u>5-24-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>May 25 50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>					

DATE REC'D BY LOCAL REG. <u>MAY 24 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Pasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>E. J. Schmitt, 2125 Lafayette</u>	
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(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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed *Joseph B. Vollmer*.....

Signed.....
Student Embalmer

Licensed Embalmer No. *4014*.....

P. O. Address *3125 Lafayette*.....

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.