

FILED OCT 25 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35492**

BIRTH NO. _____ REG. DIST. NO. **319** PRIMARY REG. DIST. NO. **590** Registrar's No. **2349**

1. PLACE OF DEATH a. COUNTY St. Louis		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 Pine Lawn		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) 2 yrs		e. STREET ADDRESS (If rural, give location) 4125 Donovan Avenue	
d. FULL NAME OF HOSPITAL OR INSTITUTION Shamrock Nursing Home			

3. NAME OF DECEASED (Type or Print) a. (First) Samuel b. (Middle) S. c. (Last) Fletcher			4. DATE OF DEATH (Month) (Day) (Year) 10 - 10 - 1955		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH 6 - 22 - 1875		9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR Months _____ Days _____	
11. IF UNDER 1 YEAR Hours _____ Mins. _____		12. CITIZEN OF WHAT COUNTRY? USA		13. BIRTHPLACE (City and State or Foreign Country) Missouri	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Section Foreman		10b. KIND OF BUSINESS OR INDUSTRY Wabash R.R.		11. BIRTHPLACE (City and State or Foreign Country) Missouri	

13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Mattie Fletcher	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 703-01-2096		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Eunice Liebel, 4125 Donovan	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) 8 <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombi		INTERVAL BETWEEN ONSET AND DEATH unknown	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardiovascular disease DUE TO (c) _____		unknown	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4221		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from **Oct 2, 1953**, to **Oct 10, 1953**, that I last saw the deceased alive on **Oct 10, 1953**, and that death occurred at **6:35 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Levin Lettman M.D.		23b. ADDRESS 8231 Clayton Rd (17)		23c. DATE SIGNED 10/12/55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/13/55		24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis County Mo.					

DATE REC'D BY LOCAL REG. 10-12-55		REGISTRAR'S SIGNATURE Herbert R. Dombrowski		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Drehmann-Harral 1905 Union Blvd.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Lewis Littman 3 - 5
8231 Clayton Rd.

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.....
Signature of Student Embalmer

Signed *Warren A. Carver*.....
Licensed Embalmer No. *35*.....

P. O. Address

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.