

FILED APR 15 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10663  
State File No. 1003  
Registrar's No. 3193

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <u>318</u>  |   | PRIMARY REG. DIST. NO. <u>1003</u>  |  | Registrar's No. <u>3193</u>  |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____   |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u><br>b. COUNTY _____ |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <u>St. Louis</u>   |  | c. LENGTH OF STAY (in this place) _____  |   | c. CITY OR TOWN <u>St. Louis</u>  |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>01</u> <u>3903a Wyoming Street</u>  |  |  |   | e. STREET ADDRESS (If rural, give location)<br><u>3903a Wyoming Street</u>  |  |  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Walter</u>  |  | b. (Middle) <u>C.</u>  |   | c. (Last) <u>Leichenauer</u>  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>Mar. 31, 1957</u>  |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>White</u>  |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Married</u>  |  | 8. DATE OF BIRTH<br><u>Aug. 27, 1893</u>   |  |
| 9. AGE (In years last birthday) <u>63</u>  |  | IF UNDER 1 YEAR Months _____ Days _____  |   | IF UNDER 1 WRS. Hours _____ Min. _____  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Chauffeur</u>  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Shapleigh Hdwe.</u> |   |  | 11. BIRTHPLACE (City and State or Foreign Country)<br><u>St. Louis, Missouri</u>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |  |   |   |  |  |  |
| 13a. FATHER'S NAME<br><u>Martin Leichenauer</u>  |  |  | 13b. MOTHER'S MAIDEN NAME<br><u>Unknown</u>                 |   |  | 14. NAME OF HUSBAND OR WIFE<br><u>Clara Marohn Leichenauer</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  |  | 16. SOCIAL SECURITY NO.<br><u>714-10-8827</u>               |   |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><u>Clara Leichenauer-3903a Wyoming St.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |  |   | MEDICAL CERTIFICATION   |  |  |  |
| <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronal Vascular Accident</u></p> <p>ANTECEDENT CAUSES</p> <p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p> <p>Due TO (b) <u>GEN. Arteriosclerosis</u></p> <p>Due TO (c) <u>331+</u></p> <p>II. OTHER SIGNIFICANT CONDITIONS</p> <p>Conditions contributing to the death but not related to the disease or condition causing death. <u>Arterio sclerotic HT dis.</u></p> |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 yrs</u>   |  |  |  |
|  |  |  |   |   |  |  |  |
|  |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION _____   |  | 19b. MAJOR FINDINGS OF OPERATION _____   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" 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) (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 <u>Jan. 1952</u> , to <u>3-31-1957</u> that I last saw the deceased alive on <u>3-31-1957</u> and that death occurred at <u>4:15 p.m.</u> , from the causes and on the date stated above.   |  |  |   |   |  |  |  |
| 23a. SIGNATURE (Degree or title)<br><u>Marvin E. Levin M.D.</u>  |  |  |   | 23b. ADDRESS<br><u>100N. Euclid</u>   |  | 23c. DATE SIGNED<br><u>4/2/57</u>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Removal</u>  |  | 24b. DATE<br><u>Apr. 3, 1957</u>   |   | 24c. NAME OF CEMETERY OR CREMATORY<br><u>Sunset Burial Park</u>   |  | 24d. LOCATION (City, town, or county) (State)<br><u>St. Louis County, Missouri</u>   |  |
| DATE REC'D. BY LOCAL REG.<br><u>APR 3 57</u>   |  | REGISTRAR'S SIGNATURE<br><u>Charles Smith M.D.</u>   |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><u>WACKER-HELDERLE - 3634 Gravois Ave.</u>  |  |  |  |

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 ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
Licensed Embalmer No. 2675  
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.