

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42576

FILED NOV 19 1957

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar No. **10718**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes Hospital</b>				Length of stay in lb <b>22 yrs</b>		STREET ADDRESS (If outside, give location) <b>#21 Thornberry Pl.</b>	
3. NAME OF DECEASED (Type or print) First <b>Augustus</b> Middle <b>Michael</b> Last <b>Schlessing</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>9</b> Year <b>1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 14, 1893</b>		9. AGE (In years last birthday) <b>64 yrs</b> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mfg. Medical Equip.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>H. Schlessing &amp; Co.</b>		11. BIRTHPLACE (City and state or country) <b>Vienna, Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Anthony Schlessing</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>488-01-0537</b>		17. INFORMANT <b>Mrs. Augustus M. Schlessing #12 Thornberry Pl.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE - (a) <b>Arteriosclerotic heart disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/>		SUICIDE <input type="checkbox"/>		HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>420.0</b>	
20c. TIME OF INJURY Hour . Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>Nov. 4 '57</b> to <b>Nov 9, '57</b> and last saw <del>him</del> <b>him</b> alive on <b>Nov. 9, '57</b> Death occurred at <b>6:50 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Anthony B. Bayle, D.</b>				22b. ADDRESS <b>3720 Washington Ave.</b>		22c. DATE SIGNED <b>11.9.57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>Nov. 11, 1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>	
24. FUNERAL DIRECTOR <b>Alexander &amp; Sons 6175 Delmar</b> ADDRESS				25. DATE RECD. BY LOCAL REG. <b>NOV-12-57</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith Mo</b> mkb	

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..

*Not embalmed*

Student .....  
Signature of Student Embalmer

Signed *Jos. E. McCulloch*

Licensed Embalmer No. *296*

P. O. Address *6177th*

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.