

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-017932  
STATE FILE NUMBER  
2107

FILED JUN 9 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Wyandotte</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Trinity Luth.</u>		Length of stay in lb <u>21 Days</u>	d. STREET ADDRESS (If outside, give location) <u>1621 South 14th</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Antone</u> Middle <u>C.</u> Last <u>Schleicher</u>			4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-12-1911</u>	9. AGE (In years last birthday) <u>47</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Postal Dep.</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Kans.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>William Schleicher</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown Rentschler</u>		14. NAME OF HUSBAND OR WIFE <u>Helen Schleicher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>496-03-8834</u>	17. INFORMANT Address <u>Helen Schleicher, 1621 South 14th</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Bronchial Pneumonia</u> DUE TO (b) <u>Carcinoma of Left Colon</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>1532</u>					INTERVAL BETWEEN ONSET AND DEATH <u>29 M.</u> <u>2/25/59+</u>
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.)		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT WORK <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 <u>2/25/58</u> to <u>4/25/59</u> and last saw <u>him</u> alive on <u>4/24/59</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>J. W. Young M.D.</u>			22b. ADDRESS <u>1401 S. W Blvd K. C. Mo.</u>		22c. DATE SIGNED <u>4/27/59</u>
22d. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Apr. 27, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Kansas</u>
24. FUNERAL DIRECTOR ADDRESS <u>Gates Funeral Home, K.C. Kans.</u>			25. DATE RECD. BY LOCAL REG. <u>4-27-59</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms with no cause in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

J. W. YOUNG

Pa 2.1023.

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 *Murray Wilson* .....

Licensed Embalmer No. *4989* .....  
P. O. Address *Parkville, Mo* .....

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.