

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022877
STATE FILE NUMBER 4776

FILED JUN 19 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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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 (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Charlack, Village</u> 4000. 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>Mo. Baptist Hosp.</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>8725 Burton Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Recil Howard Fleshman, D.C.</u>			4. DATE OF DEATH Month Day Year <u>May 15, 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>June 8, 1904</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dr. of Chiropractic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Practice</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>William Edward Fleshman</u>		13b. MOTHER'S MAIDEN NAME <u>Nellie Cottle</u>		14. NAME OF HUSBAND OR WIFE <u>Virginia G. Fleshman</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>487-44-9864</u>	17. INFORMANT <u>Mrs R.H. Fleshman</u>	Address <u>8725 Burton Ave</u>
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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>Cardiac Failure - Pulm. Edema</u> <u>Cirrhosis Liver</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>581.0</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <u>581.0</u>		
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 <u>St. Louis</u>	COUNTY <u>St. Louis Co.</u>	STATE <u>Missouri</u>
21. I attended the deceased from <u>March 29</u> to <u>May 15</u> and last saw him alive on <u>5/13/59</u> . Death occurred at <u>10:45 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>E.H. Lewicki M.D.</u> (Degree or title)		22b. ADDRESS <u>453 N. Taylor</u>	22c. DATE SIGNED <u>5/16/59</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5/18/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co, Missouri</u>
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24. FUNERAL DIRECTOR <u>Alexander & Sons</u>	ADDRESS <u>6175 Delmar Blv</u>	25. DATE RECD. BY LOCAL REG. <u>MAY 16 59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Dr.E.R.Lerwick
453 No.Taylor Ave
Fo.1-1604

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 *Gas. E. McCallon*

Licensed Embalmer No. *2460*

P. O. Address *6175 Elm*

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.