DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42140

Registration District No. 791 Primary Registration District No. _____ Registrar's No. 11263

1. PLACE OF DEATH:
(a) County St Louis Mo 1
(b) City or town _____ (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Baptist (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) Life
In this community _____

2. USUAL RESIDENCE OF DECEASED:
(a) State St Louis (b) County Mo 6
(c) City or town St Louis Mo (If outside city or town limits, write "RURAL")
(d) Street No. 4801 North Land (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Margaret Liebig
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced ✓
6. (b) Name of husband or wife Anthony Liebig 6. (c) Age of husband or wife if alive 29 years
7. Birth date of deceased 7-20-1908 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
31	5	11	hr. _____ min.

9. Birthplace St Louis Mo (City, town, or county) (State or foreign country)
10. Usual occupation Hse Wife
11. Industry or business
FATHER
12. Name Ben Swaney
13. Birthplace St Louis Mo (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Ella Connors
15. Birthplace St Louis Mo (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Anthony Liebig
(b) Address 4801 North Land
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof _____ (Month) (Day) (Year)
(c) Place: burial or cremation Calvary
18. (a) Signature of funeral director Sullivan
(b) Address 2849 No Euclid
19. (a) DEC 31 1939 (Date received local registrar) (b) J. T. Bradock (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 31st year 1939 hour 9 minute 30 pm
21. I hereby certify that I attended the deceased from _____, 19__, to _____, 19__; that I last saw h__ alive on _____, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Paralytic Ileus	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ (Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature Alfred J Perry (M. D. or other)
Address Deputy Coroner Date signed 1-2-40

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should sta[illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

Albert Maffield, Registered Apprentice No.....

working under my personal supervision.

Signed Albert Maffield

Licensed Embalmer No. 3077

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

42140
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. 791

(b) Township..... Primary Registration District No. 1003 Registered No. 11263

(c) City St Louis (d) Street No..... St.

(If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Margaret Liebig

(a) Residence, No..... St. [ ] .....

(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) MARRIED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
31	5	11	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.....

9. Industry or business in which work was done, as saw mill, bank, etc.....

10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

17. INFORMANT..... (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE..... DATE..... 19....

19. FUNERAL DIRECTOR..... (ADDRESS)

20. FILED 7/24/49 J. F. Bredeck Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-31-1939

22. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

I last saw h..... alive on ..... 19..... Death is said to have occurred on the date stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:

	Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) Alfred J. Perry M.D.

(Address) St. Louis

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of C[illegible]

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLE[illegible]