

S. No. 2
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5-17-39
P 1 X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 26 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 23919
Registrar's No. 6116

Registration District No. 128

Primary Registration District No. 2000

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Johns Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)

In this community _____ years, months or days

3. (a) PRINT FULL NAME JOSEPH LIEBICH

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Gertrude Liebich

6. (c) Age of husband or wife if alive unknown years

7. Birth date of deceased January 29, 1855
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	92	5	12	hr. min.

9. Birthplace Breslow Germany
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business Furrier

MOTHER FATHER { 12. Name Adolph Liebich

13. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

14. Maiden name Anna Krause

15. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Gertrude Liebich (wife)

(b) Address Route # 2, Box 128, City

17. (a) Burial (b) Date thereof 7/13/1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address Springfield, Missouri

19. (a) 7-12-47 (b) W S Handley
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene

(c) City or town Springfield - Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Route # 2, Box 128
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11, year 1947 hour 4: minute 20 P. M.

21. I hereby certify that I attended the deceased from July 10, 1947 to July 11, 1947; that I last saw him alive on July 11, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma Bladder Duration 6 mos.

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy None

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? _____

While at work _____ (Specify type of place)

23. Signature W S Handley (M. D. or D.D.S.)

Address Springfield, Mo Date signed 7/2/47

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

J. Cleave R. Goodrum
working under my personal supervision.

Registered Apprentice No. *473*

Signed *Jesse E. Mudd*

Licensed Embalmer No. *2831*

P. O. Address *Springfield 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 this body is not embalmed, fact should be so stated above.