

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

19625

FILED JUN 10 1953

5263

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>5263</u>				
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, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>		c. LENGTH OF STAY (in this place) <u>20 YRS.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>						
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>DE. PAUL HOSPITAL 2059</u>				d. STREET ADDRESS (If rural, give location) <u>5858. ETZEL AV.</u>						
3. NAME OF DECEASED (Type or Print) a. (First) <u>THOMAS</u> b. (Middle) <u>PETER</u> c. (Last) <u>LIEBIG</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>MAY. 24TH 1953</u>							
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER-MARRIED</u>	8. DATE OF BIRTH <u>JULY. 20TH 1887.</u>		9. AGE (In years last birthday) <u>65 YRS.</u>	if UNDER 1 YEAR Months	if UNDER 1 YEAR Days	if UNDER 1 HRS. Hours	if UNDER 1 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NIGHT-WATCHMAN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>BROCKLAND UND. CO.</u>		11. BIRTHPLACE (State or foreign country) <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>EMIL, LIEBIG</u>			13b. MOTHER'S MAIDEN NAME <u>SARAH, MC. LAUGHLIN</u>		14. NAME OF HUSBAND OR WIFE <u>SINGLE.</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES - WORLD-WAR I. DATES?</u>			16. SOCIAL SECURITY NO. <u>490-12-2823</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Emma Liebig, 5858 Etzel St. Louis</u>				ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u> ANTECEDENT CAUSES <u>Coronary Sclerosis.</u> Morbid conditions, if any, giving rise to the above cause (a) dating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH: <u>1 day</u>		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____		(COUNTY) _____		(STATE) _____		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>4201</u>						
22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>52</u> , to <u>May 24</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>May 23</u> , 19 <u>53</u> , and that death occurred at <u>7:20 A.M.</u> , from the causes and on the date stated above.										
23a. SIGNATURE <u>J. B. Hogan M.D.</u> (Degree or title)				23b. ADDRESS <u>539 N. Grand Bl. St. Louis</u>			23c. DATE SIGNED <u>5/25/53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>MAY. 27TH 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ST. BRIDGETS-CEMETERY.</u>		24d. LOCATION (City, town, or county) <u>PACIFIC.</u>		(State) <u>MO.</u>		
DATE REC'D BY LOCAL REG. <u>MAY 26 1953</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D. Brockland Und. Co.</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>M.B.</u> ADDRESS <u>1827-HOGAN, ST.</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

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
Student Embalmer

Signed

Robert M. Murray

Licensed Embalmer No. *3749*

P. O. Address *St. Louis, 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.