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FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35630

9309

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY _____
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE MISSOURI b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo. c. LENGTH OF STAY (In this place) 14 DAYS
c. CITY OR TOWN ST. LOUIS, d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Louis Chronic Hospital
e. STREET ADDRESS (If rural, give location) 2800 JANUARY Ave, 2137

3. NAME OF DECEASED a. (First) ERMA b. (Middle) _____ c. (Last) LIBLA 4. DATE OF DEATH (Month) (Day) (Year) OCTOBER 12--54

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 8. DATE OF BIRTH 5-9-1885 9. AGE (In years last birthday) 69 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) housewife 10b. KIND OF BUSINESS OR INDUSTRY at home 11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS, MISSOURI. 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME HERMAN FISCHER 13b. MOTHER'S MAIDEN NAME CAROLINE ? 14. NAME OF HUSBAND OR WIFE GEORGE LIBLA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. none 17. INFORMANT'S SIGNATURE OR NAME ADDRESS GEO. LIBLA, 2800 JANUARY AVE.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH _____
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES
DUE TO (b) with Cerebral Involvement
DUE TO (c) Decubitus Ulcers.
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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) 4500

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 9-28-, 19 54, to 10-12-, 19 54, that I last saw the deceased alive on 10-12-, 19 54, and that death occurred at 10:10 A.M. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) George M. Jamaka, M.D. 23b. ADDRESS 5800 Arsenal Street. 23c. DATE SIGNED 10/12/54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 10-15-54 24c. NAME OF CEMETERY OR CREMATORY ZION CEMETERY 24d. LOCATION (City, town, or county) (State) ST LOUIS CO., MO.

DATE REC'D BY LOCAL REG. OCT 13 1954 REGISTRAR'S SIGNATURE J. Carl Smith MO 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS ROWLAND AKER, 4104 MANCHESTER AVE.

(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.....
Signature of Student Embalmer

Signed *Allen Day*.....
Licensed Embalmer No.....
P. O. Address.....

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.