

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-030681  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8091  
FILED AUG 28 1958

S. 300  
v. 1-57

3

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
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>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
38 FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>12th &amp; Chouteau</u>		Length of stay in lb <u>63 years</u>	d. STREET ADDRESS (If outside, give location) <u>4114 Holly Hills</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Albert J. Liebermann</u>			4. DATE OF DEATH Month Day Year <u>8/18/58</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>Jan. 2, 1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Drayage Business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own business</u>	9. AGE (In years last birthday) <u>63</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Louis J. Liebermann</u>		13b. MOTHER'S MAIDEN NAME <u>May Rose Sleutermann</u>	14. NAME OF HUSBAND OR WIFE <u>Grace M. Liebermann</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <u>Yes WW #1</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Grace Liebermann</u>		Address <u>4114 Holly Hills</u>	
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>Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>420-1</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 months.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>			
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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>5-10-58</u> to <u>7-17-58</u> and last saw <sup>her</sup> him alive on <u>7-17-58</u> Death occurred at <u>7:30 A</u> -m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Walter K. Rittich</u> (Degree or title) <u>3</u>		22b. ADDRESS <u>D.C. 3407 S. Grand Blvd.,</u>	
22c. DATE SIGNED <u>8-18-58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8/21/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Missouri</u>
24. FUNERAL DIRECTOR <u>WACKER-HELDERLE</u> ADDRESS <u>3634 Gravois</u>		25. DATE RECD. BY LOCAL REG. <u>AUG 20 '58</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u> <u>S.P.</u>

STATEMENT BY LICENSED EMBALMER

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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 Delis J. Krupar

Licensed Embalmer No. 3497

P. O. Address St. Louis

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.