

DURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS NOV 6 1959

21000259-037814

STATE FILE NUMBER

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

RECOMMENDED

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, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>30 yrs.</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3312a Halliday</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3312a Halliday</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>E.</u> Last <u>LIESMANN</u>			4. DATE OF DEATH Month <u>October</u> Day <u>29,</u> Year <u>1959</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>July 6, 1883</u>	9. AGE (last birthday) <u>76 yrs.</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Merchant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	11. BIRTHPLACE (City and state or country) <u>Dixon, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Frederick Gottlieb Liesmann</u>	13b. MOTHER'S MAIDEN NAME <u>Helena Conrad</u>	14. NAME OF HUSBAND OR WIFE <u>Mrs. Sophia Donaldson Liesmann</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs. Sophia Liesmann, 3312a Halliday</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE - CONGESTIVE FAILURE</u>	DUE TO (b)	<u>3 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) <u>Senile emphysema</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>MACROCYTIC ANEMIA - POST GASTRECTOMY</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.) <u>443x</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
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21. I attended the deceased from April 1952 to OCT. 29, 59 and last saw ^{her} him alive on 10/27/59
 Death occurred at 3:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Laurel M. Forrester MD</u>	(Degree or title)	22b. ADDRESS <u>St. Louis 8 Mo</u>	22c. DATE SIGNED <u>10/30/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Oct. 31, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Memor. Gardens</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County, Missouri.</u>
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24. FUNERAL DIRECTOR <u>Beiderwieden F.H.Inc., 1936 St. Louis Ave.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>OCT 31 1959</u>	26. REGISTRAR'S SIGNATURE <u>Laurel M. Forrester, M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Dewey

Licensed Embalmer No. 452

P. O. Address Alsea

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.