

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-023515

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 1725

AMENDED

**FILED JUL 5 1961**

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WEBSTER GROVES</b>		c. CITY OR TOWN <b>Clayton</b>	
Length of stay in lb <b>39 days</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Wenwood Home &amp; Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>7712 Shirley Dr.</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Libman</b> Last <b>Libman</b>		4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/1/29</b>
9. AGE (last birthday) <b>81</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HR Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Liquor Broker</b>	11. BIRTHPLACE (City and state or country) <b>Chicago Ill</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13a. FATHER'S NAME <b>Libman</b>	
13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF DECEASED'S WIFE <b>Jennie T. Libman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. William Libman</b>		Address <b>Shirley Dr.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial insufficiency</b> <b>hypostatic pneumonia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>C.V.A. due to Generalized &amp; cerebrael</b> DUE TO (c) <b>arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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	
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.)	
20c. TIME OF INJURY Hour <b>10:55 a.m.</b> Month, Day, Year <b>May 12-1961</b>		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 <b>June 20-1961</b> COUNTY STATE	
21. I attended the deceased from <b>10:55 a.m.</b> to <b>June 20-61</b> and last saw him alive on <b>June 20-1961</b> Death occurred at <b>10:55 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Thomas T. Klyper</b> (Degree or title)		22b. ADDRESS <b>1300 Grant Rd.</b>	
22c. DATE SIGNED <b>6-20</b>		23. NAME OF CEMETERY OR CREMATORY <b>Mt. Sinai</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>6/21/61</b>	
23c. LOCATION (City, town, or county) <b>8400 Gravois Ave</b>		(State)	
24. FUNERAL DIRECTOR <b>MAYER</b> ADDRESS <b>4356 Lindell Blvd</b>		25. DATE RECD. BY LOCAL REG. <b>6-21-61</b>	
26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>			

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

**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 John J. Harris

Licensed Embalmer No. 4108

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.