

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-027752

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2166

AMENDED

FILED AUG 11 1961

1. PLACE OF DEATH a. COUNTY St. Louis b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN unincorporated area St. Louis County Length of stay in 1b yrs. 0 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2115 Kappel Drive Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis c. CITY OR TOWN unincorporated area St. Louis County Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 2115 Kappel Drive Residence on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLEMENS LIEBOLD			4. DATE OF DEATH Month Day Year August 2, 1961
5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH DEC 19 1864 9. AGE (last birthday) 96
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman (retired)		10b. KIND OF BUSINESS OR INDUSTRY Steel Industry	11. BIRTHPLACE (City and state or country) Germany
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Vincent Liebold	13b. MOTHER'S MAIDEN NAME not known
14. NAME OF HUSBAND OR WIFE Mary Liebold		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
17. INFORMANT Address Halls Ferry Nursing Home 2115 Kappel Dr.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease INTERVAL BETWEEN ONSET AND DEATH unknown Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary Emphysema, Gout 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 a.m. p.m. Month, Day, Year	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
21. I attended the deceased from Oct 11, 1949 to Aug 2, 1961 and last saw him alive on July 31, 1961 Death occurred at 7:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Lewis Littmann MD	22b. ADDRESS 8231 Clayton Rd (17)	22c. DATE SIGNED (State) 8/2/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE Aug. 3, 1961	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR ADDRESS M.J. Croghan, 7146 Manchester Av., St. Louis	25. DATE RECD. BY LOCAL REG. 8-2-61	26. REGISTRAR'S SIGNATURE J. C. Murphy M.D.	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

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.

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