

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41303

FILED NOV 19 1953
BIRTH NO.

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

State File No.
Registrar's No. 9819

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MISSOURI		c. LENGTH OF STAY (In this place) 11 days	c. CITY OR TOWN Posedale
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) TOBI THA b. (Middle) E. c. (Last) VanLieu		4. DATE OF DEATH (Month) (Day) (Year) OCTOBER 14 1953	
5. SEX Female	6. COLOR OR RACE White.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married.	8. DATE OF BIRTH Apr. 3, 1897.
9. AGE (In years last birthday) 56	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady	10b. KIND OF BUSINESS OR INDUSTRY J.C. PENNY. CO.	11. BIRTHPLACE (City and State or Foreign Country) / Lyford Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME William VanLieu.	
13b. MOTHER'S MAIDEN NAME Kate Buchanan		14. NAME OF HUSBAND OR WIFE -----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 317-03-7849	
17. INFORMANT'S SIGNATURE OR NAME Gerogia VanLieu,		ADDRESS Vincennes Ind.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CHRONIC MYELOID LEUKEMIA ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 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 <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 2041	
22. I hereby certify that I attended the deceased from 10-3- , 19 53 , to 10-14 , 19 53 , that I last saw the deceased alive on 10-14 , 19 53 , and that death occurred at 2:40a.m. , from the causes and on the date stated above.			
23a. SIGNATURE FR Bradley		23b. ADDRESS BARNES HOSPITAL	
(Degree or title) M.D.		23c. DATE SIGNED 10-14-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-14-53.	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Terre Haute Ind.
DATE REC'D BY LOCAL REG. OCT 14 1953	REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe Inc. 4700 Washington.	

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, ~~of~~, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Edmond R. Ruel*

Licensed Embalmer No. *4283*

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.