

Health,
Welfare
Public
Service

300
1-56

doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 16 1956

36313

STATE FILE NUMBER

318

1003

9182

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

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, Mo.</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"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5255 Page Ave.</u>			Length of stay in lb <u>16 yrs. 2/6</u>		STREET ADDRESS (If outside, give location) <u>5255 Page Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Viola</u> Middle <u>NMN</u> Last <u>Tobin</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>7</u> Year <u>1956</u>				
5. SEX <u>Female</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>Nov. 25, 1899</u>	9. AGE (In years last birthday) <u>56</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>New Philadelphia, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Liedtke</u>				14. MOTHER'S MAIDEN NAME <u>Jane Robertson</u>				
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 Address <u>Mr. Eugene T. Tobin, 5255 Page Ave.</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>Myeloid Metaplasia</u> <u>Myelosclerosis</u> DUE TO (b) <u>Polycythemia vera 16 yrs.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH	
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>294x</u>					
20c. TIME OF INJURY Hour <u>7:00 P.M.</u> Month, Day, Year a. m. p. m.								
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 <u>Tilden, Illinois</u>			COUNTY <u>M.D.</u>	STATE <u>Illinois</u>
21. I attended the deceased from <u>1939</u> to <u>Oct. 4, 1956</u> and last saw ^{her} alive on <u>Oct. 4, 1956</u> Death occurred at <u>7:00 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>C. P. Vermillion, M.D.</u>				22b. ADDRESS <u>Barnes Hospital</u>		22c. DATE SIGNED <u>10/8/56</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>10/10/56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Tilden Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Tilden, Illinois</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Calvin F. Beutz, Funeral Home, Inc.</u> <u>1828 Natural Bridge, St. Louis, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>OCT 8 1956</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>mbs</u>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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..... *Ralph E. Lindner*

Licensed Embalmer No. *42*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.