

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-033945
STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 366
FILED SEP 30 1958

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|---|------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>St. Francois</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> COUNTY <u>St. Louis, County</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Francois Township</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN <u>Unknown</u> | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital # 4</u> | | Length of stay in lb <u>29yrs, 11mo, 16 day</u> | d. STREET ADDRESS (If outside, give location) <u>Unknown</u> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>EMILLIE</u> Middle <u>LIEBL</u> Last <u>ROCK</u> | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>20</u> Year <u>1958</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 11, 1889</u> | 9. AGE (In years last birthday) <u>69</u> | IF UNDER 1 YEAR Months <u>8</u> Days <u>9</u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 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>Sheboygan, Wisconsin</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>Jack Liebl</u> | | 13b. MOTHER'S MAIDEN NAME <u>Katherine Liebl (unrelated)</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>John J. Rock</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Records State Hospital # 4</u> | | Address <u>Farmington, Missouri</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>Coronary thrombosis</u> DUE TO (b) <u>Myocardial damage and anterior coronary disease as revealed by electrocardiogram on 7-28-58.</u> DUE TO (c) <u>4201 H</u> | |
| 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 <u> </u> Month, Day, Year a.m. <u> </u> p.m. <u> </u> | | 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>Farmington, Missouri</u> | | 20g. COUNTY <u> </u> | | 20h. STATE <u> </u> | |
| 21. I attended the deceased from <u>Oct. 6, 1928</u> to <u>Sept. 20, 1958</u> and last saw her alive on <u>Sept. 20, 1958</u> Death occurred at <u>8:15 P. M.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> (Degree or title) | | | 22b. ADDRESS <u>State Hospital No. 4 Farmington, Missouri</u> | | 22c. DATE SIGNED <u>9-20-58</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Sept. 22, 1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>New Calvary</u> | | 23d. LOCATION (City, town, or country) (State) <u>Farmington, Missouri</u> | |
| 24. FUNERAL DIRECTOR <u>Cozean Funeral Home, Farmington, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>Sept. 20, 1958</u> | | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Chicozeau*

Licensed Embalmer No. *4084*
P. O. Address *Farmington*

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.