

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

30396

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Law Primary Registration District No. 1002
 City Manassas City No. 2609 Olive

File No. 513
 Registered No. 513
 St. _____ Ward _____

2. FULL NAME

John P. Loosen
 (a) Residence No. 2609 Olive St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 19-1863
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
64 | 8 | 25
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Supt
 (b) General nature of industry, business, or establishment in which employed (or employer) American Ry Ex Co
 (c) Name of employer Retired

9. BIRTHPLACE (CITY OR TOWN) Wis e
 (STATE OR COUNTRY)
 10. NAME OF FATHER Rudolph Loosen
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Germany
 12. MAIDEN NAME OF MOTHER Unknown
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) Germany

14. INFORMANT Irvin Loosen
 (Address) 2609 Olive
 15. FILED 10/16, 1927 M. M. Crowe
 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct-14 1927
 17. Sept 27 I HEREBY CERTIFY, That I attended deceased from _____ 1927, to Oct 14 1927
 that I last saw him alive on Oct 14 1927 and that death occurred, on the date stated above, at 11:08 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Myocardia
936
1370
 CONTRIBUTORY (SECONDARY) Chronic Myocarditis
unknown to me
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? St. F. Hanel M. D.
Whis (Address) 900 Kiallo Blvd.
 _____ 1927

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt Moriah DATE OF BURIAL 10-17 1927
 20. UNDERTAKER Miss C L Foster ADDRESS 918 Brooklyn

THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rec of Int. Bldg

7.