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

Do not use this space.

17526

1. PLACE OF DEATH

County ..... Registration District No. 1-92 ..... File No. .....

Township ..... Primary Registration District No. ..... Registered No. 4603

City St. Louis (No. 4036a North 9th Street St. ..... Ward)

2. FULL NAME Adam Loeb

(a) Residence. No. 4036a North 9th St., 26 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. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Elizabeth Harden Loeb (nee Hicks)

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 18, 1866

7. AGE: Years 63 | Months 9 | Days 20 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Labor Employee
(b) General nature of industry, business, or establishment in which employed (or employer): Mississippi Glass Co.
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Germany

PARENTS

10. NAME OF FATHER Philip Loeb
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Germany

14. INFORMANT Mrs. Elizabeth Loeb
(Address) 4036a North 9th Street

15. FILED ....., 19 ..... Ray C. Vaughn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 8 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 28, 1930, to May 8, 1930 that I last saw ~~him~~ alive on May 7th, 1930 and that death occurred, on the date stated above at 9 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Mediastinal Sarcoma 47 yr
Not Known (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. ..... mos. ..... ds.

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18. WHERE WAS DISEASE CONTRACTED? —
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Pay of Physical Findings
(Signed) Ray J. Schuster, M. D.
, 19 (Address) 2800a Chippewa St.

*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: Valhalla — DATE OF BURIAL: May 10 1930

20. UNDERTAKER: Math Hermann and Son — ADDRESS: 2126 E. Florissant.

N. B.—Every item of information should be given. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

JUN 23 1948