

REC'D FEB 10 1939

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

791

1003

715

Do not use this space.

715

## 1. PLACE OF DEATH

(a) County ..... Registration District No. ....  
 (b) Township ..... Primary Registration District No. ....  
 (c) City St. Louis (d) Street No. City Hospital No. 1 St. ....  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

Anna Loeser  
 (a) Residence, No. 3726 Ohio St. 24 (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 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 MARTIN LOESER.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 18, 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
80 3 5

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc. nil

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

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

13. NAME William Temme

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

15. MAIDEN NAME ?

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ?

17. INFORMANT (ADDRESS) Hosp. Info M. Kent

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Paul Churchyard DATE Jan 25, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Burkwood Funeral Home  
1926 St. Louis Ave.

20. FILED JAN 24 1939 J. B. Budrick  
Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/23/39 19

22. I HEREBY CERTIFY, That I attended deceased from 1/17/39, 19, 1/23/39, 19

I last saw her alive on 1/23/39, 19. Death is said to have occurred on the date stated above 1:30 a. m.

The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage  
Causes phatomalacia

Date of onset  
1-8-39  
1-8-39

Other contributory causes of importance:

Name of operation none Date of 5

What test confirmed diagnosis? none Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) J. B. Budrick, M. D.

(Address) City Hospital No. 1

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No. *3737*

P. O. Address. *1936 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 this body is not embalmed, above space should be left blank.**