

MAR 9 1939

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

5425
Do not use this space.

1. PLACE OF DEATH *Jackson*

(a) County *Jackson* Registration District No. *399*

(b) Township *Kaw* Primary Registration District No. *1002*

(c) City *K. C. Mo.* (d) Street No. *507* *Elmwood* St.

(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 *Albert Ernest Loehning*

(a) Residence, No. *507 Elmwood* St. (If nonresident, give city or town and State)

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 *Mrs. Myrtle Loehning*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *March 29, 1878*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.

60 10 13

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

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

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) *Wisconsin*

13. NAME *Ernest Edward Loehning*

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

15. MAIDEN NAME *No Record*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *No Record*

17. INFORMANT (ADDRESS) *Jack Loehning*
507 Elmwood

18. BURIAL, CREMATION, OR REMOVAL PLACE *Green Lawn* DATE *Feb. 15, 1939*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *John W. Wagner*
Kansas City, Mo.

20. FILED *2/14 1939 M. M. Browne*
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb. 12, 1939*

22. I HEREBY CERTIFY, that I attended deceased from *Jan. 1925* to *Jan 12, 1939*

I last saw him alive on *about Jan 1939*. Death is said to have occurred on the date stated above, *9:30 a.m.*

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

Cerebral Hemorrhage

Other contributory causes of importance:

Hyper tension
arteriosclerosis

Name of operation *Py. Exam* Date of _____

What test confirmed diagnosis? *Py. Exam* 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? *No*

If so, specify _____

(Signed) *W. P. East* M. D.

(Address) *927 N. 9th St. Berkeley*
Kan. City Mo

A. E.—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.

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.....

P. O. Address.....

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.