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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15639

FILED APR 28 1944
Registration District No. 3058

Primary Registration District No. 3058

State File No. _____
Registrar's No. 54

1. PLACE OF DEATH:
(a) County St. Charles
(b) City or town St. Charles
(c) Name of hospital or institution: St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days
In this community life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Charles
(c) City or town St. Peters, rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? YES NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Kathrine Loeffler

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Joseph Loeffler 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct. 24 1866
(Month) (Day) (Year)

8. AGE: Years 77 Months 4 Days 24 If less than one day _____ hr. _____ min.

9. Birthplace St. Peters, Mo. (City, town, or county) (State or foreign country) 0

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Anton Schneider
13. Birthplace St. Peters, Mo. (City, town, or county) (State or foreign country)
14. Maiden name Iffrig
15. Birthplace St. Peters, Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Anton Loeffler
(b) Address St. Peters, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-44 (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters, Mo.

18. (a) Signature of funeral director Geo. Stisgater

(b) Address St. Peters, Mo.

19. (a) 3/20/44 (Date received local registrar) (b) Ernst St. Paul (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19 year 1944 hour 6 minute 15 A. M.

21. I hereby certify that I attended the deceased from March 6, 1944 to March 19, 1944
that I last saw her alive on March 18, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death: Thrombo. Angitis Obliterans Duration 2 months

Due to Arteriosclerosis ?

Due to _____

Other conditions chronic nephritis ?
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 131

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Joe J. [unclear] (M. D. or other)

Address St. Peters, Mo. Date signed 3-20-44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 4-27-44

MAY 2 1944

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.....

E. A. Keethly

Licensed Embalmer No.

P. O. Address.....

877
D. Fallon Md

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, fact should be so stated above.