

FILED FEB 5 1945

State File No.

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2754

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Overland
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Berliner Nursing Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Overland
(If outside city or town limits, write "RURAL")

(d) Street No. Ashby & Thorpe Rd.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM P. LOTH

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 5
year 45 - hour 5 - minute 30 P.M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from Dec. 1, 1944 to Jan. 5, 1945
that I last saw him alive on Jan. 4, 1945
and that death occurred on the date and hour stated above.

7. Birth date of deceased Unknown
(Month) (Day) (Year)

Immediate cause of death Bacterial Pneumonia Duration 2 day

8. AGE:	Years	Months	Days	If less than one day
About	<u>74</u>			hr. _____ min. _____

Due to 107

Due to _____

9. Birthplace Germany
(City, town, or county) (State or foreign country)

Other conditions Chronic Myo. Carditis years _____
(Include pregnancy within 3 months of death)

10. Usual occupation Physician

Major findings:
Of operations None

Of autopsy None

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

11. Industry or business _____

12. Name Adolph Loth

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Block

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Victor Loth
(b) Address 809 Huntington Rd.

17. (a) Burial (b) Date thereof 1-7-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Sinai Cemetery

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

(a) Accident, suicide, or homicide (specify) No.

(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? _____

18. (a) Signature of funeral director H. T. Bonds
(b) Address 5216 Delmar Blvd.

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

19. (a) JAN 9 1945 (b) E. J. McDevaney (c) 24 318 - Woodson Rd
(Date received local registrar) (Registrar's signature) (Address)

19. (a) _____ (b) _____ (c) _____
(Date received local registrar) (Registrar's signature) (Address)

23. Signature Dr. A. Maibach (M. D. or other) M.D.
Date signed 1-6-45

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

1-36

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 *H. Burgess*

Licensed Embalmer No. 4029

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, fact should be so stated above.