

S. No. 2
M-5-43
7. 5-17-39
I X38671

FILED MAR 16 1945

Registration District No. 318 Primary Registration District No. Registrar's No. 2236

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital #1.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 66 years
years, months or days)

3. (a) PRINT FULL NAME Julius Loser

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Mathilda

6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased November 27 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

66 3 11 _____ hr. _____ min.

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

10. Usual occupation Spotter, Cleaning & Dyeing

MOTHER FATHER {

11. Industry or business _____

12. Name CHRIST. LOSER

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

14. Maiden name KATHERINE

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

16. (a) Informant Mrs. Carl Burdick

(b) Address 6743 Fyler

17. (a) Cremation (b) Date thereof March 10 '45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director Beiderwieden F.H. Inc.

(b) Address 1936 St. Louis Avenue

19. (a) MAR 9 1945 (b) J. F. Burdick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 2129 Esther
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 8th
year 1945 hour 12:55 minute A. M.

21. I hereby certify that I attended the deceased from 2/18/45
_____, 19____, to 3/8/45, 19____.

that I last saw h. im alive on 3/8/45, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial failure Duration _____

Due to Acute bilateral pyelonephritis - non-calculous + Arterio-sclerotic heart disease - lung

Due to _____

Other conditions urethral strictures
(Include pregnancy within 3 months of death)

Major findings: J.F.D. PHYSICIAN _____

Of operations _____

Of autopsy _____

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)

(c) Means of injury 0

23. Signature H. Kingblade, Jr. (M. D. or other) _____

Address 1515 Lafayette 3/8/45

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed.....
Glenn W. Watz

Licensed Embalmer No. *3732*

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, fact should be so stated above.