S. No. 2
0M—2-43
v. 5-17-39
I X35697

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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 9 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

10027

State File No.

Registration District No. 114 Primary Registration District No. 3035 Registrar's No. 11

1. PLACE OF DEATH

(a) County Lafayette
(b) City or town Lexington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: N. 10th St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 15 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Lafayette
(c) City or town Lexington 54
(If outside city or town limits, write "RURAL")
(d) Street No. N. 10th St 3
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME MICHAL J. LOEB
3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex Ma
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Edith Page
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased April 29 - 1872
(Month) (Day) (Year)

8. AGE: Years 71 Months 10 Days 11 If less than one day hr. min.

9. Birthplace (City, town, or county) Germany (State or foreign country)
10. Usual occupation Painter
11. Industry or business
FATHER
12. Name John Loeb
13. Birthplace (City, town, or county) Germany (State or foreign country)
MOTHER
14. Maiden name Not Known
15. Birthplace (City, town, or county) Germany (State or foreign country)
16. (a) Informant Mrs. Edith Loeb
(b) Address Lexington, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-14-45 (Month) (Day) (Year)
(c) Place: burial or cremation Lexington, Mo
18. (a) Signature of funeral director Forrest F. Tempel
(b) Address Lexington, Mo
19. (a) April-4-45 (Date received local registrar) (b) Mrs. Fred Schwab (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 10 year 1945 hour 9 minute 30 P.M.
21. I hereby certify that I attended the deceased from Mar 8, 1945, to Mar 10, 1945; that I last saw him alive on Mar 10, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute pulmonary edema Myocarditis	3 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature [signature] (M. D. or other)
Address Lexington Mo Date signed 3/10/45

112 8

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8
District File Number

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 J. L. McKean

Licensed Embalmer No. 2983

P. O. Address Lexington, Mo

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.