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5-17-39  
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THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. **594**  
Registrar's No. **277**

**FILED** JAN 21 1946  
318

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

**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-Max C. Starkloff Memorial  
(If not in hospital or institution, write street number or location)

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

In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 026

(c) City or town St. Louis 617  
(If outside city or town limits, write "RURAL")

Street No. 5626 Roosevelt  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 8

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** WALTER LOESCHE

3. (b) If veteran, name war Nil

3. (c) Social Security No. Unknown

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

7. Birth date of deceased January 14th, 1884  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>61</u>	<u>11</u>	<u>25</u>	hr. _____ min. _____

9. Birthplace Red Bud Illinois  
(City, town, or county) (State or foreign country)

10. Usual occupation Watchman

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**

12. Name Max Loesche

13. Birthplace Unknown Germany  
(City, town, or county) (State or foreign country) 4

14. Maiden name Mathilda Linders

15. Birthplace Red Bud Germany  
(City, town, or county) (State or foreign country) 11

16. (a) Informant Anita Loesche

(b) Address 3109 Abner Pl.

17. (a) Removal (b) Date thereof 1/11/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Red Bud, Illinois

18. (a) Signature of funeral director Albert H. Hopper  
(b) Address \_\_\_\_\_

19. (a) JAN 9 1946 (b) [Signature]  
(Date received local Registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan. day 9th  
year 1946 hour 3:50 minute A M.

21. I hereby certify that I attended the deceased from 12/29/45  
\_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw h. alive on 1/9/46, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death arteriosclerotic heart disease

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

**PHYSICIAN**

Major findings:  
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) \_\_\_\_\_ means of injury \_\_\_\_\_

23. Signature Herbert C. Fritz (M.D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
2793

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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.....

*Robert H. Hays*

Licensed Embalmer No..... *2971*

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.**