

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11371

State File No. _____
Registrar's No. **2385**

FILED MAR 20 1946
318

1003

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1519 Destrahan 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 52 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 080
(c) City or town St. Louis 176
(If outside city or town limits, write "RURAL")
(d) Street No. 1519 Destrahan St.
(If rural, give location) 4
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME LOUISE LOCHMANN
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 9th
year 1946 hour 11 minute 00 A.M.

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife John A. Lochmann
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 27 1863
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 10 1944 to Mar 9 1946
that I last saw her alive on Mar 8 1946
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
82 10 12 hr. min.

Immediate cause of death Chronic Myocarditis
Duration _____

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

Due to _____
Due to _____

10. Usual occupation Housewife

Other conditions: Angina Pectoris
(Include pregnancy within 3 months of death)
Chr. Interstitial Nephritis

11. Industry or business _____

Major findings: _____
Of operations _____

12. Name William Flick

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

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

14. Maiden name Susana (Unknown)

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

16. (a) Informant Mrs. Louise Walsh
(b) Address 1519 Destrahan St.

17. (a) Burial (b) Date thereof March 12, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Bethlehem Cemetery

18. (a) Signature of funeral director Beiderwieden F.H., Inc.
(b) Address 1936 St. Louis Ave.

19. (a) MAR 12 1946 (b) J. F. Brediek
(Date received local registrar) (Registrar's signature)

Of autopsy _____

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 Dr. A. A. Welch (M. D. or other) (M.D.)
Address 3901 W. Florissant Date signed 3/11/46

10283
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Wied
3901⁶ W. Howard
1:30 PM to 3 PM

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 *Max L. Wanzel*

Licensed Embalmer No. *4170*

P. O. Address. *5325 Staska St.*

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.