S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 11 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 32742

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9173

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:
Alexian Bros. Hospital
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis 76

(c) City or town ~~Saint Louis~~ Lemay
(If outside city or town limits, write "RURAL")

(d) Street No. 225 Dammert
(If rural, give location)

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

3. (a) PRINT FULL NAME Otto E. Loser

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Martha B.

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased December 25th, 1875
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
71	9	6	hr. min.

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

10. Usual occupation Un-employed

11. Industry or business

FATHER
12. Name Christ Loser
13. Birthplace Germany
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Katherene Kock
15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Martha B. Loser
(b) Address 225 Dammert

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4, 1947
(Month) (Day) (Year)
(c) Place: burial or cremation Sunset Burial Pk.

18. (a) Signature of funeral director Wacker-Heldele Und. Co.
(b) Address 3634 Gravois, St. Louis, Mo.

19. (a) OCT 3 (Date received local registrar) (b) J. F. Bresick (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Oct. day 1st
year 1947 hour 7: minute 08 P. M.

21. I hereby certify that I attended the deceased from Sept 15, 1947 to October 1, 1947
that I last saw him alive on Oct 1, 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Mitral insufficiency	10 yrs.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Chronic Interstitial nephritis	Chronic

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 7707 Lyons Date signed 10/3/47

(Licensed Embalmer's Statement on Reverse Side)

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..... Frank J. Hyland

Licensed Embalmer No. 2645

P. O. Address St Louis 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.