

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21313**
5141
Registrar's No.

FILED JUN 23 1951

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.	c. LENGTH OF STAY (In this place) 2 days	c. CITY (If outside corporate limits, write RURAL and give township) Patton	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital		d. STREET ADDRESS (If rural, give location) Route #1	

3. NAME OF DECEASED (Type or Print) a. (First) FLORENCE b. (Middle) ALPHA c. (Last) LOBERG			4. DATE OF DEATH (Month) (Day) (Year) 6-1-51		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH June 29, 1880	9. AGE (In years last birthday) 70	10. UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Perry Co., Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Peter Conrad		13b. MOTHER'S MAIDEN NAME Helen Flee		14. NAME OF HUSBAND OR WIFE Thomas Loberg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sherman Loberg, Perryville, Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4 mos.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of transverse colon		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus Pneumonia		10 yrs. 3 days	

19a. DATE OF OPERATION 5/18/51		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 152X	

22. I hereby certify that I attended the deceased from **5-8-1951**, to **6-1-1951**, that I last saw the deceased alive on **6-1-1951**, and that death occurred at **6:57 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE FR Mueller (Degree or title) M. D.		23b. ADDRESS Barnes Hospital		23c. DATE SIGNED 6/1/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 6-1-51		24c. NAME OF CEMETERY OR CREMATORY Patton	
		24d. LOCATION (City, town, or county) (State) Patton, Mo.			

DATE REC'D BY LOCAL REG. JUN 4 1951		REGISTRAR'S SIGNATURE J. B. Lanster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEC 21 1951

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.

Student Embalmer No.....

Signed.....

Robert M Murray

Signed.....
Student Embalmer

Licensed Embalmer No. *3749*

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.