

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

3412

0969

FILED FEB 11 1953

|  |  |                        |  |   |  |                                     |  |  |  |                                    |  |  |  |                                |  |
|--|--|------------------------|--|---|--|-------------------------------------|--|--|--|------------------------------------|--|--|--|--------------------------------|--|
| BIRTH NO.  |  | REG. DIST. NO. 318     |  | PRIMARY REG. DIST. NO. 1003   |  | Registrar's No. 0969                |  |  |  |                                    |  |  |  |                                |  |
| 1. PLACE OF DEATH<br>a. COUNTY   |  |                        |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE Mo.   |  |                                     |  | b. COUNTY  |  |                                    |  |  |  |                                |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>St. Louis  |  |                        |  | c. LENGTH OF STAY (in this place)<br>50 yrs.  |  |                                     |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>St. Louis 2069 |  |                                    |  |  |  |                                |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br>5025 Highland Ave.  |  |                        |  | d. STREET ADDRESS (If rural, give location)<br>5025 Highland Ave.   |  |                                     |  | 0  |  |                                    |  |  |  |                                |  |
| 3. NAME OF DECEASED<br>(Type or Print)   |  | a. (First)<br>John     |  | b. (Middle)<br>B.   |  | c. (Last)<br>Loftus                 |  | 4. DATE OF DEATH (Month) (Day) (Year)<br>Jan. 26, 1953                                 |  |                                    |  |  |  |                                |  |
| 5. SEX<br>M.   |  | 6. COLOR OR RACE<br>W. |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br>M.  |  | 8. DATE OF BIRTH<br>April 22, 1868  |  | 9. AGE (In years last birthday)<br>84  |  | IF UNDER 1 YEAR<br>Months 9        |  | IF UNDER 24 HRS.<br>Days 4   |  | IF UNDER 12 HRS.<br>Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired Tailoring Salesman  |  |                        |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |                                     |  | 11. BIRTHPLACE (City and State or Foreign Country)<br>Ohio                             |  |                                    |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.                                     |  |                                |  |
| 13a. FATHER'S NAME<br>Patrick J. Loftus  |  |                        |  | 13b. MOTHER'S MAIDEN NAME<br>Ellen Malloy   |  |                                     |  | 14. NAME OF HUSBAND OR WIFE<br>Mrs. Patricia Loftus                                    |  |                                    |  |  |  |                                |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>NO   |  |                        |  | 16. SOCIAL SECURITY NO.<br>not known  |  |                                     |  | 17. INFORMANT'S SIGNATURE OR NAME<br>Miss Eva Mary Loftus                              |  |                                    |  | ADDRESS<br>5025 Highland Ave.  |  |                                |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.  |  |                        |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cor. In. Vascular Renal Disease</i>  |  |                                     |  |  |  |                                    |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>3 yrs</i>                         |  |                                |  |
|  |  |                        |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <i>Hypertension</i>             |  |                                     |  |  |  |                                    |  | <i>2 yrs +</i>   |  |                                |  |
|  |  |                        |  | DUE TO (c) <i>Arteriosclerosis</i>  |  |                                     |  |  |  |                                    |  | <i>3 yrs +</i>   |  |                                |  |
|  |  |                        |  | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><i>Prostatic hypertrophy</i> |  |                                     |  |  |  |                                    |  | <i>1 year</i>  |  |                                |  |
| 19a. DATE OF OPERATION   |  |                        |  | 19b. MAJOR FINDINGS OF OPERATION  |  |                                     |  |  |  |                                    |  | 20. AUTOPSY?<br>YES <input 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?<br><i>442X</i>  |  |                                    |  |  |  |                                |  |
| 22. I hereby certify that I attended the deceased from <i>Jan 1</i> 18 <sup>52</sup> to <i>Jan 26</i> 19 <sup>53</sup> , that I last saw the deceased alive on <i>Jan 13</i> , 19 <sup>53</sup> , and that death occurred at <i>4:30 PM.</i> from the causes and on the date stated above. |  |                        |  |   |  |                                     |  |  |  |                                    |  |  |  |                                |  |
| 23a. SIGNATURE<br><i>Reverend Lane</i>   |  |                        |  |   |  | 23b. ADDRESS<br><i>1117 N Grand</i> |  |  |  | 23c. DATE SIGNED<br><i>1/27/53</i> |  |  |  |                                |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  |                        |  | 24b. DATE<br><i>Jan. 29, 1953</i>   |  |                                     |  | 24c. NAME OF CEMETERY OR CREMATORY<br><i>Calvary Cemetery</i>                          |  |                                    |  | 24d. LOCATION (City, town, or county) (State)<br><i>St. Louis, Mo.</i>   |  |                                |  |
| DATE REC'D BY LOCAL REG.<br><i>JAN 27 1953</i>   |  |                        |  | REGISTRAR'S SIGNATURE<br><i>J. Carl Smith</i>   |  |                                     |  | FUNERAL DIRECTOR'S SIGNATURE<br><i>Arthur J. Hommel</i>                                |  |                                    |  | ADDRESS<br><i>3840 Lindell Blvd.</i>                                     |  |                                |  |

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

**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 me

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed [Signature]

Licensed Embalmer No. 4699

P. O. Address St. Charles, 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.