

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3413**
Registrar's No. **0999**

FILED FEB 11 1953

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

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo 2269	
d. FULL NAME OF HOSPITAL OR INSTITUTION Ehroute City Hospital		d. STREET ADDRESS (If rural, give location) 1947 a Benton St 0	
3. NAME OF DECEASED a. (First) Michael (Type or Print)		b. (Middle) J	c. (Last) Loftus
4. DATE OF DEATH (Month) (Day) (Year) 1 26 53			
5. SEX 0 male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 8-24-1895
9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 12 HRS. Hours Mtn.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Check Clerk		10b. KIND OF BUSINESS OR INDUSTRY Katy R.R	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo 0
12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME Peter Loftus		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Thresa Loftus
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. # 1 194-03-3443	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Thresa Loftus 1947 a Benton St
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Coronary Thrombosis 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.	
19a. DATE OF OPERATION		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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4201	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:51 m., from the causes and on the date stated above.			
22a. SIGNATURE Patrick E Taylor Currier (Degree or title)		22b. ADDRESS 1300 Clark	22c. DATE SIGNED 1.28.53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Feb 20 1953	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Co
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JAN 28 1953 J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Goodhart-Hoodhart 2228 St. Louis, Av		

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Robert M. Murray

Licensed Embalmer No. 37491

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.