

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11915

State File No. ....

FILED MAR 31 1953

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 2692

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3225 Minnesota Av		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis 2169	
3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) T c. (Last) Loida		4. DATE OF DEATH (Month) (Day) (Year) March 9 1953	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept 6 1866
9. AGE (In years last birthday) 86		10. UNDER 1 YEAR Months	11. UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Shoe	12. CITIZEN OF WHAT COUNTRY? U S
11. BIRTHPLACE (City and State or Foreign Country) Czechoslovakia 6		12. CITIZEN OF WHAT COUNTRY? U S	
13a. FATHER'S NAME Joseph Loida		13b. MOTHER'S MAIDEN NAME Rose Mayer	14. NAME OF HUSBAND OR WIFE Kate
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Kate Loida 3225 Minnesota Av
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) Acute Cardiac Dilatation INTERVAL BETWEEN ONSET AND DEATH 1 day  ANTECEDENT CAUSES DUE TO (b) Carcinoma Throat 2 mos. DUE TO (c) Metastases to left lung 3 wks  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Nephritis Interstitial 3 yrs	
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) None		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) None		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR		148X	
22. I hereby certify that I attended the deceased from Jan 8, 1953, to Mar 9, 1953, that I last saw the deceased alive on Mar 9, 1953, and that death occurred at 4 P. M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) W. J. Macalambé Rm		23b. ADDRESS 2767 Lewis Street No 310 53	
23c. DATE SIGNED 3 10 53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 3/13/52	
24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		24d. LOCATION (City, town, or county) (State) St Louis Mo.	
DATE REC'D BY LOCAL REG. MAR 10 1953		REGISTRAR'S SIGNATURE Carl Smith	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Moydell Funeral Home 1926 Allen Av	

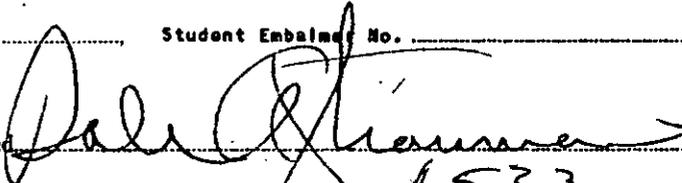
**STATEMENT BY LICENSED EMBALMER**

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  \_\_\_\_\_

Licensed Embalmer No. 4533

P. O. Address J. L. Smith

**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.