

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12838

State File No. _____

Unknown 14 300 113
R. # 108891
FILED MAR 21 1953

REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 746

1. PLACE OF DEATH a. COUNTY ST. LOUIS		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 JEFFERSON BARRACKS, MO.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2119	
c. LENGTH OF STAY (In this place) 4 days		d. STREET ADDRESS (If rural, give location) 1580 KENNERLY	
d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSP.			

3. NAME OF DECEASED (Type or Print) LEO J. LOESCH			4. DATE OF DEATH (Month) (Day) (Year) 3-6-53	
5. SEX 0 MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED 0	8. DATE OF BIRTH 5-5-09	9. AGE (In years last birthday) 43
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROWER		10b. KIND OF BUSINESS OR INDUSTRY FLORIST	11. BIRTHPLACE (City and State or Foreign Country) AUSTRIA 4	
12. CITIZEN OF WHAT COUNTRY? USA				

13a. FATHER'S NAME JOSEPH LOESCH		13b. MOTHER'S MAIDEN NAME JOSEPHINE BENDEL		14. NAME OF HUSBAND OR WIFE NONE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 497 03 8321	17. INFORMANT'S SIGNATURE OR NAME VA HOSPITAL RECORDS, JEFF. BKS, MO.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL HEMORRHAGE, MASSIVE		DUPLICATE (b) HYPO PROTHROMBINEMIA		6 days
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUPLICATE (c) CIRRHOSIS OF LIVER		Unknown
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				Unknown

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 5810		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. VA		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from 3-2-53, 1953, to 3-6-53, 1953, that I last saw the deceased on 3-6-53, and that death occurred at 7:35A m., from the causes and on the date stated above.

23a. SIGNATURE J. P. KAMINSKAS, M.D.		23b. ADDRESS VA HOSP. JEFF. BRKS, MO:		23c. DATE SIGNED 3-6-53
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24a. BURIAL OR CREMATION REMOVAL (Specify) Burial		24b. DATE 3-9-53	24c. NAME OF CEMETERY OR CREMATORY National Cem.		24d. LOCATION (City, town, or county) (State) Jeff. Brks, Mo.
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DATE REC'D BY LOCAL REG. 3-7-53		REGISTRAR'S SIGNATURE Herbert R. Donke		25. FUNERAL DIRECTOR'S SIGNATURE Southern Funeral Home	
				ADDRESS 6322 S. Grand Ave. Home	

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

FEB 24 1954

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

David Van Fossan

Licensed Embalmer No. *4342*

P. O. Address *6322 So Grand*

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.