

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33623
8135

FILED SEP 24 1953

State File No. _____
Registrar's No. _____

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 Mo. b. COUNTY			
b. CITY OR TOWN St. Louis,		c. CITY OR TOWN St. Louis,		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: 3722a Virginia Ave.		e. STREET ADDRESS (If rural, give location) 3722a Virginia Ave.			

3. NAME OF DECEASED (Type or Print)	a. (First) WILLIAM	b. (Middle) F.	c. (Last) LOCHMOELLER, SR.	4. DATE OF DEATH (Month) (Day) (Year) Aug. 20, 1953
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 16, 1885	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Sup.	10b. KIND OF BUSINESS OR INDUSTRY Prudential Ins.	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME William F. Lochmoeller	13b. MOTHER'S MAIDEN NAME Margaret Oppel	14. NAME OF HUSBAND OR WIFE Clara R. Lochmoeller
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No.	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME William F. Lochmoeller, Jr. ADDRESS Carlstad 6014
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Nephrosclerosis		5 mo.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Prostatic Hypertrophy DUE TO (c)		5 mo.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) 610X
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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?
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22. I hereby certify that I attended the deceased from **Mar**, 19**52**, to **Aug 20**, 19**53**, that I last saw the deceased alive on **Aug 20**, 19**53**, and that death occurred at **2:05 P** m., from the causes and on the date stated above.

23a. SIGNATURE John G. Matthew M.D. (Degree or title)	23b. ADDRESS 3707 Watson Rd	23c. DATE SIGNED 8-21-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-24-53	24c. NAME OF CEMETERY OR CREMATORY New St Marcus	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL AUG 21 1953	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser-4228 S. Kingshighway Bl. ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Richard W. Storvick*.....

Licensed Embalmer No...400.....

P. O. Address

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.