

FILED AUG 2-1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24049

5531

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b>				b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <b>ST. LOUIS</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>ST LOUIS</b>		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 <b>EN ROUT TO ALEYIAN BROS.</b>				STREET ADDRESS (If rural, give location) <b>5984 Theodore</b>				<b>2019</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>EDWARD</b>		b. (Middle) _____		c. (Last) <b>LOSEMANN</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>JUNE 25 1955</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>JULY 10 1892</b>			
9. AGE (In years last birthday) <b>62</b>		IF UNDER 1 YEAR Months _____		IF UNDER 24 HRS. Hours _____		Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>These Cypres</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis Mo.</b>		12. CITIZEN OF WHAT COUNTRY? _____			
13a. FATHER'S NAME <b>Mr. Losemann</b>		13b. MOTHER'S MAIDEN NAME <b>Wm. Hennhaus</b>		14. NAME OF HUSBAND OR WIFE <b>Emma</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>499-05-3911</b>		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS <b>Emma Losemann 5984 Theodore</b>					
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) <b>Coronary Heart Failure</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>sclerosis</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND 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) <b>4500</b>					
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? _____					
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 <b>7:20 AM.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>James M. Keey</b> (Print Name or Title) _____				23b. ADDRESS <b>1300 Clark</b>		23c. DATE SIGNED <b>6-27-55</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24b. DATE <b>6-28-55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>			
DATE REC'D BY LOCAL REG. <b>JUN 27 1955</b>		REGISTRAR'S SIGNATURE <b>Carl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <b>JOS. P. FENDLER JR 7128 Michigan</b>					

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 *Clarence Rocho*

Licensed Embalmer No. *309*

P. O. Address *7158 Mc*

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.