

FILED MAR 13 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

7357

Registration District No. 302 Primary Registration District No. 4531 Registrar's No. 86

1. PLACE OF DEATH a. COUNTY <u>WARREN</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>WARREN</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WARRENTON</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>WARRENTON</u> <sup>1090</sup>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>KATIE JANE HOME</u>		Length of stay in lb <u>2 1/2 YRS</u>		d. STREET ADDRESS (If outside, give location) <u>KATIE JANE HOME</u>	
3. NAME OF DECEASED (Type or print) First <u>CORNEILA</u> Middle <u>LOEB</u> Last <u>LOEB</u>			4. DATE OF DEATH Month <u>MARCH</u> Day <u>8</u> Year <u>1957</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 20 1876</u>	9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DRESS FACTORY</u>		11. BIRTHPLACE (City and state or country) <u>HERMANN Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13. FATHER'S NAME <u>FERDINAND LOEB</u>		
14. MOTHER'S MAIDEN NAME <u>LOUISA EBERLIN</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>STONE</u>			17. INFORMANT Address <u>HERMANN Mo</u> <u>MYRTLE WAGNER</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4) Generalized Convulsion / Interle</u> <u>rigid bite mechanism</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>2) Scurvy</u> DUE TO (c) <u>1) Scurvy</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)					INTERVAL BETWEEN ONSET AND DEATH <u>174</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>0</u>			20c. TIME OF INJURY Hour <u>0</u> Month <u>0</u> Day <u>0</u> Year <u>0</u> a. m. <u>0</u> p. m. <u>0</u>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY <u>WARREN</u> STATE <u>MO</u>	
21. I attended the deceased from <u>July 20 57</u> to <u>March 8 57</u> and last saw her <u>alive</u> on <u>March 5 1957</u> . Death occurred at <u>6:20 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Lloyd Lagon</u>			22b. ADDRESS <u>Wagoner Mo</u>		22c. DATE SIGNED <u>2-9-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>3/11/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HERMANN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>HERMANN Mo</u>
24. FUNERAL DIRECTOR <u>HUGO H. BLUMER</u>		ADDRESS <u>HERMANN Mo</u>		25. DATE RECD. BY LOCAL REG. <u>3-9-57</u>	26. REGISTRAR'S SIGNATURE <u>Lloyd Lagon</u>

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Service

800-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Coroner cannot certify to a death due to natural causes. No symptoms will be noted. No symptoms in Part I must be casually related. Doctor, coroner, etc. must use only standard nomenclature in Part I. No symptoms will be noted. No symptoms in Part I must be casually related.

MEDICAL CERTIFICATION

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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.....

*Joseph H. Danner*  
Licensed Embalmer No. 316

P. O. Address *Herrmann*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If  
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.