

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14969

FILED APR 26 1957

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1003

State File No.

3655

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
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 town or township) Saint Louis		c. LENGTH OF STAY (in this place) 34 Years		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 01 4580 Kennerly Avenue, 13, 2				e. STREET ADDRESS (If rural, give location) 1170 4580 Kennerly Avenue, 13.			
3. NAME OF DECEASED (Type or Print) a. (First) Joseph b. (Middle) _____ c. (Last) Loesch			4. DATE OF DEATH (Month) (Day) (Year) April 13th, 1957				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 10th, 1876	9. AGE (in years last birthday) 81	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work or department of working life, even if retired) Stone mason		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (City and State or Foreign Country) Austria-Hungary		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Thresa Eckl		14. NAME OF HUSBAND OR WIFE Josephine Loesch			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 497-09-9869A		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Adolph Loesch, 5404 Union Blvd.,			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Pharynx - metastases ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> 148X DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> Generalized Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 18 mos years	
19a. DATE OF OPERATION Feb 1957		19b. MAJOR FINDINGS OF OPERATION Squamous Cell Carcinoma of perineum (metastatic)				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)			
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 <u>1955</u> to <u>April</u> , 1957, that I last saw the deceased alive on <u>April 10, 1957</u> , and that death occurred at <u>5:45P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) M. A. Cassel, M.D.				23b. ADDRESS 2801 N. Taylor		23c. DATE SIGNED April 13 '57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4/17/57		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	
DATE REC'D BY LOCAL REG. APR 16 '57		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS CALVIN F. FEUTZ, 4828 Natural Bridge Blvd. FUNERAL HOME, INC., St. Louis, 15, Missouri.			

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 *Roy C. Fendler*.....

Licensed Embalmer No. *4275*.....

P. O. Address *St. Louis, Mo.*.....

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.