

FILED SEP 17 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33802

STATE FILE NUMBER
8243

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>1</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS Mo</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>ST. LOUIS</i>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST. ANTHONY'S HOSPITAL</i>		Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <i>3225 MINNESOTA</i>	
3. NAME OF DECEASED (Type or print) <i>CLARA</i> First <i>LOIDA</i> Last		4. DATE OF DEATH Month <i>SEPT</i> Day <i>2</i> Year <i>1957</i>			
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>MAR. 2 1898</i>	9. AGE (In years last birthday) <i>59</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SEAMSTRESS</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>GALC + SOBEL</i>		11. BIRTHPLACE (City and state or country) <i>Missouri</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>JOHN LOIDA</i>			14. MOTHER'S MAIDEN NAME <i>KATE FALOUT</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>493-05-9783</i>		17. INFORMANT Address <i>LILLIAN BECKER 3225 MINNESOTA</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>					INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <i>332x</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <i>glaucoma</i>					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.)			
20c. TIME OF INJURY. Hour _____ a. m. _____ p. m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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 STATE	
21. I attended the deceased from <i>1850</i> to <i>9-2-57</i> and last saw her <i>alive</i> on <i>9-2-57</i> Death occurred at <i>3 1/2 A</i> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Royce E. Thierman, M.D.</i>		22b. ADDRESS <i>5203 Chippewa</i>		22c. DATE SIGNED <i>9-4-57</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>		23b. DATE <i>SEPT 5 1957</i>		23c. NAME OF CEMETERY OR CREMATORY <i>SUNSET BURIAL</i>	
23d. LOCATION (City, town, or county) <i>ST. LOUIS Mo</i>		23e. (State) <i>Mo</i>			
24. FUNERAL DIRECTOR ADDRESS <i>Thomas Kates 2906 Prairie</i>		25. DATE RECD. BY LOCAL REG. <i>SEP 3 '57</i>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith M.D.</i>	

(Licensed Embalmer's Statement on Reverse Side)

300
1-56

All symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

m86

5103
JL 2-6017
Whipple

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Samuel C. Bell

Licensed Embalmer No. 434

P. O. Address 2906

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