

Health, & Welfare  
 Public Service  
 300  
 1-57  
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. Item 13 b altered by order of funeral dir.  
 All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

**38524**  
 STATE FILE NUMBER

FILED OCT 28 1957

Registration District No. 317 Primary Registration District No. 543 Registrar's No. 2556

<b>1. PLACE OF DEATH</b> a. COUNTY <u>St. Louis</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Jennings</u>		c. CITY OR TOWN <u>Jennings</u> <u>4138</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2543 Ada Avenue</u>		d. STREET ADDRESS (If outside, give location) <u>2543 Ada Avenue</u>	
Length of stay in lb <u>1 year</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Louis</u> Middle <u></u> Last <u>Lochmoeller</u>			<b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>15</u> Year <u>1957</u>
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Jan. 3, 1877</u>
<b>9. AGE</b> (In years last birthday) <u>80</u>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>St. Louis, Mo.</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Dairyman</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
<b>13a. FATHER'S NAME</b> <u>Wilhelm Lochmoeller</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <del>Alma Kellmann</del> <u>DINA NEUKIACH</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>Mrs Alma Lochmoeller (Deceased)</u>
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>	<b>17. INFORMANT</b> <u>Mr Belmont Lochmoeller, 5382 Claxton Avenue,</u>
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apoplexy</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>334X</u>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 min.</u> <u>15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <u></u>	
<b>20c. TIME OF INJURY</b> .Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		<u></u>	
<b>20d. INJURY OCCURRED WHILE AT</b> <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> <b>AT WORK</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u>	<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE <u></u>
<b>21. I attended the deceased from</b> <u>1945 Oct 15/57</u> and last saw her/him alive on <u>Oct 14-57</u> Death occurred at <u>12:00 Noon</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
<b>22a. SIGNATURE</b> <u>[Signature]</u> (Degree or title)		<b>22b. ADDRESS</b> <u>6204 W. Florence</u>	<b>22c. DATE SIGNED</b> <u>Oct 16/57</u>
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>10-18-1957</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Peters Cemetery</u>	<b>23d. LOCATION</b> (City, town, or county) (State) <u>St. Louis, County, Mo.</u>
<b>24. FUNERAL DIRECTOR</b> <u>Math Hermann &amp; Son, Inc., 2161 E. Fair</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>10-16-57</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Hebecl R. Donke, MD</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION

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 .....  
*John N. [unclear]*

Licensed Embalmer No. 3737  
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.