

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042676

STATE FILE NUMBER

FILED NOV 17 1958

Registration District No. 317

Primary Registration District No. 546

Registrar's No. 2735

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-57
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1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR Overland TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Overland Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2440 Northland		Length of stay in lb 902	d. STREET ADDRESS (If outside, give location) 2440 Northland Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last CHARLES MASON LOEWE			4. DATE OF DEATH Month Day Year Oct. 23 1958		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24 1874	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR Months Days Hours Min. 10 29	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Mgr. Traffic Dept.	10b. KIND OF BUSINESS OR INDUSTRY Emerson Electric	11. BIRTHPLACE (City and state or country) Louisville Kentucky	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Mathias Loewe	13b. MOTHER'S MAIDEN NAME Emma Ehrlich	14. NAME OF HUSBAND OR WIFE Mary Barbara Loewe
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Spanish-American	16. SOCIAL SECURITY NO. unk.	17. INFORMANT Mary Loewe Address 2440 Northland
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerosis		1 yr 5
	DUE TO (c) Diabetes		260x 4 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
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20d. INJURY OCCURRED WHILE AT <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 STATE
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21. I attended the deceased from Aug. 1955 to 10-23-58 and last saw him alive on Oct 17, 58 Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Melvin B. Greenman M.D.	22b. ADDRESS 634 North Grand Avenue	22c. DATE SIGNED 10/24/1958
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23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 10/25/1958	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory	23d. LOCATION (City, town, or county) (State) 7800 St. Charles Rock Road
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24. FUNERAL DIRECTOR C.R. Lupton and Sons 7233 Delmar	25. DATE RECD. BY LOCAL REG. 10-24-58	26. REGISTRAR'S SIGNATURE Herbert K. Dombi, M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*
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.