

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015330

STATE FILE NUMBER

2 4122

FILED MAY 15 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

Registrar No. 4122

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>ST. LOUIS</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>AFFTON</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>DEACONESS Hosp.</i>		Length of stay in 1b <i>9 wks</i>	d. STREET ADDRESS (If outside, give location) <i>7209 WEBER RD</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>JOHANNA LOESCH</i>			4. DATE OF DEATH Month Day Year <i>APRIL 25 1959</i>
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAR. 19 1899</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>AT Home</i>	11. BIRTHPLACE (City and state or country) <i>AUSTRIA HUNGARY</i>
13a. FATHER'S NAME <i>FRANK KINDLER</i>		13b. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	14. NAME OF HUSBAND OR WIFE <i>SYLVESTER LOESCH</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>NONE</i>	17. INFORMANT Address <i>SYLVESTER LOESCH AFFTON, Mo</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>Carcinoma</i>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Carcinoma left ovary</i>			<i>2 yrs</i>
DUE TO (c) <i>175.0</i>			
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? 1 YES <input checked="" type="checkbox"/> NO <input 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 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>1958</i> to <i>4/25/59</i> and last saw her alive on <i>4/24/59</i> Death occurred at <i>4 A</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Loan Smith</i> (Degree or title)		22b. ADDRESS <i>3915 Jackson Rd.</i>	22c. DATE SIGNED <i>4-27-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>APRIL 28 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>S. S. Peter &amp; Paul</i>	23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS Mo</i>
24. FUNERAL DIRECTOR <i>Thomas Kuter 2906 Beavris</i>	25. DATE RECD. BY LOCAL REG. <i>APR 27 '59</i>	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

2015

M. 17 - 4221  
FILL 5 30 P.M.

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 James C. Will

Licensed Embalmer No. 4347  
P. O. Address 2306 Duane

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.