

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030588

FILED VS SEP 1 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2-7675

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>35 yrs.</u>	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Missouri Baptist Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5720 Roosevelt Pl.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward Loesche</u>			4. DATE OF DEATH Month Day Year <u>August 17, 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/7/1888</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (City and state or country) <u>Red Bud, Ill.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>Max Loesche</u>		13b. MOTHER'S MAIDEN NAME <u>Mathilda Linders</u>		14. NAME OF HUSBAND OR WIFE <u>Dora</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>498-07-2842</u>	17. INFORMANT Address <u>Dora Loesche, 5720 Roosevelt Pl.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease & cerebral arteriosclerosis.</u> DUE TO (b) _____ DUE TO (c) <u>420.0</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Lobar pneumonia right middle & lower lobe</u>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 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 <u>July 22, 1959</u> to <u>Aug 17, 1959</u> and last saw ^{her} him alive on <u>Aug 18, 1959</u> . Death occurred at <u>4:05 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Hugo F. Bergman M.D.</u>			22b. ADDRESS <u>3720 Washington</u>		22c. DATE SIGNED <u>8/18/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-20-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis Co., Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Albert H. Hoppe, Inc., 4700 Washington Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>AUG 18 1959</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

L.P.

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed W. W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address St Louis

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.