

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-020686
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5119

FILED MAY 31 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in lb <u>2 days</u>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY		c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chronic Hosp</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3825 a Dunnica</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lydia Losemann</u>				4. DATE OF DEATH Month Day Year <u>5 18 62</u>				5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-30-77</u>		9. AGE (last birthday) <u>84</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Factory Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Waste Paper Material</u>				11. BIRTHPLACE (City and state or country) <u>Mo. - St. Louis, Mo.</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>											
13a. FATHER'S NAME <u>Gerhardt Losemann</u>				13b. MOTHER'S MAIDEN NAME <u>Wilhelmin a Bauman</u>				14. NAME OF HUSBAND OR WIFE <u>single</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.				17. INFORMANT Address <u>Lydia Luebbert 3825a Dunnica</u>			
18. CAUSE OF DEATH (Enter only one cause per line) PART I - DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Atherosclerosis</u>												INTERVAL BETWEEN ONSET AND DEATH <u>years</u>											
CONDITIONS, if any, which gave rise to above cause, stating the underlying cause, if any. DUE TO (b) <u>Generalized Atherosclerosis</u>												INTERVAL BETWEEN ONSET AND DEATH <u>years</u>											
DUE TO (c) <u>334XF</u>																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Head Injury and Fracture Rt. Radius</u>												PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input checked="" 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.) <u>Fell down stairs</u>																			
20c. TIME OF INJURY Hour a.m. p.m. <u>5/10/62</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>16</u>		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE													
21. I attended the deceased from <u>5-16-62</u> , to <u>5-18-62</u> and last saw her/him alive on <u>5-18-62</u> Death occurred at <u>7:20 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.																							
22a. SIGNATURE (In green or blue) <u>George M. Janaka, M.D.</u>						22b. ADDRESS <u>5600 Arsenal</u>				22c. DATE SIGNED <u>5/21/62</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>5-21-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>																	
24. FUNERAL DIRECTOR ADDRESS <u>Suedmeyer & Sons 3934 N. 20th St.</u>				25. DATE RECD. BY LOCAL REG. <u>MAY 21 1962</u>		26. REGISTRAR'S SIGNATURE <u>Lead Smith, M.D.</u>																	

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 J. Haines

Licensed Embalmer No. 4108

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.