

**MISSOURI STATE BOARD OF HEALTH**  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF DEATH**

Do not use this space.

40953

**1. PLACE OF DEATH**

County.....

Registration District No.....

791

1003

Township.....

Primary Registration District No.....

City.....

*St. Louis* 6121 Alabama Ave

File No.....

11611

Registered No.....

St. .... Ward)

**2. FULL NAME**

(a) Residence. No. .... St. .... Ward. ....

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX

*Female*

4. COLOR OR RACE

*White*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

*Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

*Frank Fiock*

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

*Nov 10<sup>th</sup> 1878*

7. AGE

YEARS  
*52*

MONTHS  
*1*

DAYS  
*0*

If LESS than 1 day, .... hrs. or .... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *House Wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

*St. Louis Mo.*

(STATE OR COUNTRY)

10. NAME OF FATHER

*Adam Loesch*

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Germany*

12. MAIDEN NAME OF MOTHER

*Elizabeth Amos*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

*Germany*

14.

INFORMANT

(Address)

*Frank Fiock*  
*6121 Alabama Ave*

15.

FILED

NOV 19

*Max C. Stanley*  
REGISTRAR

2

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR)

*12-10-1930*

17.

I HEREBY CERTIFY, That I attended deceased from *12-8-1930* to *12-10-1930* that I last saw him alive on *12-9-1930* and that death occurred, on the date stated above, at *12<sup>05</sup> A.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Chronic Myocarditis*  
*131*  
*93e*

CONTRIBUTORY (SECONDARY)

*Chronic Pericarditis*  
*atrous nephritis*  
*Don't know*  
*Don't know*

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH. Y. N. D. DATE OF

20. WAS THERE AN AUTOPSY.

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

*D. S. Pruell*, M. D.

*12-10-1930* (Address) *6006 Virginia*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

*St. Trinity Lutheran*

*Nov. 12<sup>th</sup> 1930*

20. UNDERTAKER

*Wm. Schumacher*

ADDRESS

*8013 Meramec*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

