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

Do not use this space. 16303

1. PLACE OF DEATH

County ..... Registration District No. 791 File No. .....

Township ..... Primary Registration District No. 1003 Registered No. 4173

City St Louis Mo (No. 5237 Beacon Ave St. ..... Ward)

2. FULL NAME Lorenz Wurm

(a) Residence. No. ..... St., 7 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: Male
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~~ Sophie Wurm

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 5th 1876

7. AGE: YEARS 50 | MONTHS 8 | DAYS 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Plasterer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Germany

PARENTS

10. NAME OF FATHER Lawrence Wurm
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Not Known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Germany

14. INFORMANT Mrs Sophie Wurm
(Address) 5237 Beacon Ave

15. FILED MAY -3 1927 19.. May C Starkcoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 1st 1927

17. I HEREBY CERTIFY, That I attended deceased from Apr 1st, 1927, to May 1st, 1927, that I last saw h.. alive on May 1st, 1927, and that death occurred, on the date stated above, at 11 05 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
GASTRIC CARCINOMA
46B
44A
(duration) ..... yrs. ..... mos. 30 ds.

CONTRIBUTORY (SECONDARY) Chronic Gastritis
(duration) ..... yrs. ..... mos. 90 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? USUAL SYMPTOMS

(Signed) C. E. Aldenderfer M.D

5/2, 1927 (Address) 5555 Robin Av

*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: Calvary | DATE OF BURIAL: May 3rd 1927

20. UNDERTAKER: Math Hermann & Son | ADDRESS: 4103 W Floussant Ave

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.

PERMANENT RECORD