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

Do not use this space.

38369

File No. .....

Registered No. 11034

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St Louis (No. 6115 Lucille Ave. St. ..... Ward)

2. FULL NAME Wm Lenz.

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*)
Male	White	Widow

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wilhelmina Lenz.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mch 14 1826

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	101	8	25	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

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

(c) Name of employer

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

PARENTS

10. NAME OF FATHER Wm Lenz

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

14. INFORMANT Wm Lenz
(Address) 737 Aubert Av.

15. FILED DEC 10 1927 Marl B Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 9 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec 3, 1927, to Dec 9, 1927, that I last saw h. alive on Dec 9, 1927, and that death occurred, on the date stated above, at 12:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy, Cerebral Hemorrhage
87.0
1 hr (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (SECONDARY) Senility
(duration) 1 yrs. ..... mos. ..... 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. Aldendorfer, M. D.

12/9, 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	DATE OF BURIAL
Memorial Park.	Dec 11 1927
20. UNDERTAKER	**ADDRESS**
Thos. H. Budnimann	1936 St L. Av

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.

WHEN FILLED, WITH OTHER INFORMATION, THIS IS A PERMANENT RECORD