

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City St. Louis, Mo.

Registration District No. 791
Primary Registration District No. 1003
(No. Jewish Hospital)

File No. 28419
Registered No. 8299
St. Ward)

2. FULL NAME Dorothy Lohrenz

(a) Residence. No. 6836 Waldemar Avenue St. 4 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) November 7th, 1896

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>33</u>	<u>9</u>	<u>12</u>	

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer Oliver Anderson Brokers

9. BIRTHPLACE (CITY OR TOWN) St. Louis,
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Rudolph Lohrenz

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis,
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Sophia Koenig

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis,
(STATE OR COUNTRY) Missouri.

14. INFORMANT Rudolph Lohrenz
(Address) 6836 Waldemar Avenue

15. FILED AUG 20 1930
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8/19 1930

17. I HEREBY CERTIFY, That I attended deceased from 8/18/30 1930, to 8/19 1930, that I last saw her alive on 8/19 1930, and that death occurred, on the date stated above, at 11:30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

115A Agammaglobulinemia
107A
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Bronchopneumonia
(duration) yrs. mos. ds.

18. DID AN OPERATION PRECEDE DEATH? NO DATE OF 8/19
WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) Julius Elson M. D.
8/19 1930 (Address) Jewish Hospital

*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 Lakewood Park DATE OF BURIAL Aug. 21 19 30

20. UNDERTAKER Wacker-Heldrich ADDRESS 2531 S. Bldwy.

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.

