DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26358

Registration District No. 784 — JUL AUG 5 1940

Primary Registration District No. 117

Registrar's No. 1403

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Webster Groves (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Nil (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Nil (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Webster Groves (If outside city or town limits, write "RURAL")

(d) Street No. 456 Oak St (If rural, give location)

(e) If foreign born, how long in U. S. A.? 60 years.

3. (a) PRINT FULL NAME Robert Wm. Lorenz 652

3. (b) If veteran, name war nil

3. (c) Social Security No. 498-09-3447

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Elizabeth Lorenz

6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased Jan. 9, 1876 (Month) (Day) (Year)

8. AGE: Years 64 Months 6 Days 18 If less than one day hr. min.

9. Birthplace Leipsig (City, town, or county) Germany (State or foreign country) 6

10. Usual occupation Terra Cotta worker 6

11. Industry or business

FATHER
12. Name Unknown 6
13. Birthplace (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) Germany (State or foreign country)

16. (a) Informant's own signature Elizabeth Lorenz

(b) Address 456 Oak St

17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof 7/29/40 (Month) (Day) (Year)

(c) Place: burial or cremation VALHALLA CREMATORY

18. (a) Signature of funeral director ~~ATT FELBERG FUNERAL HOME, Inc.~~ ~~WEBSTER GROVES, MO.~~

(b) Address

19. (a) JUL 29 1940 (Date received local registrar) (b) T. R. Meyer M.D. Dr. O.H. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 27 year 1940 hour 5 minute 25 M.

21. I hereby certify that I attended the deceased from July 3, 1940, to July 24, 1940 that I last saw him alive on July 24, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hearth Disease	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature Dr Joseph H. Scharf (M. D. or other)

Address 2500 N. Grand Blvd Date signed July 27/40

(Licensed Embalmer's Statement on Reverse Side)

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.

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 1122

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w/ the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

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STANDARD CERTIFICATE OF DEATH

State File No. 26358

Registration District No. ____ Primary Registration District No. ____ Registrar's No. 14 D 3

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Webster Groves
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

3. (a) PRINT FULL NAME Robert H. Lorenz

3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife ____ 6. (c) Age of husband, or wife, if alive ____ years

7. Birth date of deceased ____ (Month) (Day) (Year)

8. AGE: Years ____ Months ____ Days ____ If less than one day ____ hr. ____ min.

9. Birthplace ____ (City, town, or county) (State or foreign country)

10. Usual occupation ____

11. Industry or business ____

12. Name ____
13. Birthplace ____ (City, town, or county) (State or foreign country)

14. Maiden name ____
15. Birthplace ____ (City, town, or county) (State or foreign country)

(a) Informant ____
(b) Address ____

(a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)

(c) Place: burial or cremation ____

(a) Signature of funeral director ____
(b) Address ____

(a) 7-29-40 (Date received local registrar) (b) Jos. H. Scharf (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State ____ (b) County ____
(c) City or town ____ (If outside city or town limits write "RURAL")
(d) Street No. ____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 27 day 40 year ____ hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw h. alive on ____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Heart Disease
acute myocarditis

Due to ____

Due to ____

Other conditions ____ (Include pregnancy within 3 months of death)

Major findings:
Of operations ____
Of autopsy 930

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____
While at work? ____ (Specify type of place) (e) Means of injury ____

23. Signature Scott Schaaf (M. D. or other)
Address 6000 N. Crestwood Date signed 7-29-40

SUPPLEMENTARY