S. No. 300
v. 10.48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED JUN 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21361

BIRTH NO. 37787-49 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5240

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. John's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
d. STREET ADDRESS (If rural, give location) 5019 Queens Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) Infant
b. (Middle) Lorenz (Male) – Twin #2
c. (Last)

4. DATE OF DEATH (Month) (Day) (Year) June 16, 1949

5. SEX M.
6. COLOR OR RACE W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S.
8. DATE OF BIRTH June 15, 1949
9. AGE (In years last birthday) — If under 1 year: Months — Days 23-23 — If under 24 hrs.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Emil R. Lorenz
13b. MOTHER'S MAIDEN NAME Marcelle Kuntz
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Mr. Emil R. Lorenz, **ADDRESS** 5019 Queens Ave.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Prematurity

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

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776X

22. *I hereby certify that I attended the deceased from* June 15, 1949, *to* June 16, 1949, *that I last saw the deceased alive on* June 16, 1949, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE R. J. Marion (Degree or title) M.D.
23b. ADDRESS Mo Theatre Bldg
23c. DATE SIGNED June 17-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 17, 1949
24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
24d. LOCATION (City, town, or county) St. Louis, Mo. (State)

DATE REC'D BY LOCAL REG. JUN 17 1949
REGISTRAR'S SIGNATURE J. B. Lasater
FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly
ADDRESS 3840 Lindell Blvd.

(Licensed Embalmer's Statement on Reverse Side)

Not Embalmed

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.....

....., Student Embalmer No. .....,

working under my personal supervision.

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.