

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9512
2381

State File No.

Registrar's No.

XC-1 561 469
Reg. 6561 SL-4694

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No.	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN 915 N. Grand, St. Louis, Mo.		c. LENGTH OF STAY (in this place) 31 days		c. CITY OR TOWN ST. LOUIS		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration H osp.				STREET ADDRESS (If rural, give location) 6186 Washington Avenue			
3. NAME OF DECEASED (Type or Print) a. (First) Robert		b. (Middle) _____		c. (Last) DE LORENZO		4. DATE OF DEATH (Month) (Day) (Year) 3-14-55	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 7-19-97		9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY Brown Shoe Company		11. BIRTHPLACE (City and State or Foreign Country) Rartin, New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Angelo DeLorenzo		13b. MOTHER'S MAIDEN NAME Maria Pivrotto		14. NAME OF HUSBAND OR WIFE Marie DeLorenzo			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. U492-01-7195		17. INFORMANT'S SIGNATURE OR NAME ADDRESS VA Hosp. Records, 915 N. Grand, St. Louis, Mo.			
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) RECURRENT CARCINOMA OF ESOPHAGUS WITH METASTASES TO LIVER, PERITONEUM 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 PERITONITIS DUE TO PERFORATED RECTAL METASTASIS 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 <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) NONE		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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 150X			
22. I hereby certify that I attended the deceased from 2-11-55 , 19____, to 3-14-55 , 19____, and that death occurred at 9:30 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE W. H. Haeflinger, M.D.				23b. ADDRESS VA HOSP. 915 N. Grand, St. Louis, Mo.		23c. DATE SIGNED 3-14-55	
24a. BURIAL CREMATION (Specify) Burial		24b. DATE March 17, 1955		24c. NAME OF CEMETERY OR CREMATORY Calvary Mausoleum		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. MAR 15 1955		REGISTRAR'S SIGNATURE Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE Alexander & Sons		ADDRESS 6175 Delmar Blvd	

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

VS APR 25 1900

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..

Student.....
Signature of Student Embalmer

Signed *Jos. E. McCulloch*

Licensed Embalmer No. *2460*

P. O. Address *6175 Palma*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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