

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

24274  
6005

FILED AUG 2-1955

State File No. ....

BIRTH NO. \_\_\_\_\_ -REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (If this place) <b>14 days</b>		e. STREET ADDRESS (If rural, give location) <b>17 1646 South 39th Street 21790</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>			

3. NAME OF DECEASED (Type or Print) <b>Laura</b>		a. (First)	b. (Middle)	c. (Last) <b>Renz</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>July 10, 1955</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Singler</b>	8. DATE OF BIRTH <b>May 27, 1874</b>	9. AGE (In years last birthday) <b>81</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Mins
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stenographer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Public Service</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Fred Renz</b>	13b. MOTHER'S MAIDEN NAME <b>Laura Fischer</b>	14. NAME OF HUSBAND OR WIFE <b>Single</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <b>Eugenia Renz</b>	ADDRESS <b>1646 South 39th Str.</b>
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of the ovaries</b>		
	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. <b>Post-op hypotension and uremia</b>			

19a. DATE OF OPERATION <b>6/29/55</b>	19b. MAJOR FINDINGS OF OPERATION <b>right ovary cyst plus carcinoma of both ovaries with metastasis to uterus</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>175x</b>
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22. I hereby certify that I attended the deceased from **6/20/55**, 19\_\_\_, to **7/10/55**, 19\_\_\_, that I last saw the deceased alive on **7/10/55**, 19\_\_\_, and that death occurred at **9:10A** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Morton W. Klein M.D.</b>	(Degree or title) <b>M.D.</b>	23b. ADDRESS <b>St. Louis Jewish Hospital</b>	23c. DATE SIGNED <b>7/11/55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	24b. DATE <b>July 12, 55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Lake Charles</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>
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DATE REC'D BY LOCAL REG. <b>JUL 12 1955</b>	REGISTRAR'S SIGNATURE <b>Carl Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>William Schumacher</b>	ADDRESS <b>3013 Meramec st.</b>
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*mgs* (Licensed Embalmer's Statement on Reverse Side)

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

**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..... *Jack Haupt*  
Licensed Embalmer No..... *478*  
P. O. Address..... *St. Louis*

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.