

FILED OCT 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31165

State File No. 8667

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8667**

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 OR TOWN ST. LOUIS Mo)		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHN'S Hosp.		e. STREET ADDRESS (If rural, give location) 15 4448 TAFT 215 90			

3. NAME OF DECEASED (Type or Print) a. (First) JOSEPH b. (Middle) LORENZ c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) OCT. 3 1955		
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5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH FEB. 6 1868		9. AGE (in years last birthday) 87		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Missouri				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME WILLIAM LORENZ		13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE EMMA LORENZ (DEC'D)	
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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. NONE		17. INFORMANT'S SIGNATURE OR NAME OLIVIA NAES ADDRESS 4060 TAFT	
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) arteriosclerotic heart dis				INTERVAL BETWEEN ONSET AND DEATH unknown	
		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.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 420.0				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from **5/4**, 19**54** to **10-3**, 19**55**, that I last saw the deceased alive on **10-3**, 19**55**, and that death occurred at **8:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Nemessy J (Degree or title) MD		23b. ADDRESS 634 Toland		23c. DATE SIGNED 10/4/55	
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24a. BURIAL, CREMATION REMOVAL (Specify) REMOVAL		24b. DATE OCT 6 1955		24c. NAME OF CEMETERY OR CREMATORY IMMACULATE CONCEPTION		24d. LOCATION (City, town, or county) (State) MAXVILLE, Mo	
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DATE REC'D BY LOCAL REG. OCT 4 1955		REGISTRAR'S SIGNATURE Charles Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutas ADDRESS 2906 Genois	
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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 *Henry C. Hill*.....

Licensed Embalmer No. *434*.....

P. O. Address *2906*.....

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.