

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030185

FILED VS SEP 15 1959

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. Registrar's No. 346

| | | | | | | | |
|---|---|---|---------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | | | |
| a. COUNTY St. Francois | | b. CITY (If outside corporate limits, give TOWNSHIP only) St. Francois Twp. Farmington RURAL | | a. STATE Mo. | | b. COUNTY City of St. Louis | |
| Length of stay in 1b 2 Yrs. 13 das. | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #4 | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS 6463 Scanlon Ave. | | | |
| 3. NAME OF DECEASED (Type or print) | | | | 4. DATE OF DEATH | | | |
| First EDWARD | | Middle F. | | Last LORENZ | | Month Day Year Sept. 5, 1959 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 11-28-1900 | 9. AGE (last birthday) 58 | IF UNDER 1 YEAR Months Days 9 8 | IF UNDER 24 HR Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman-Steel Industry | | 10b. KIND OF BUSINESS OR INDUSTRY St. Louis, Mo. | | 11. BIRTHPLACE (City and state or country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME David G. Lorenz | | 13b. MOTHER'S MAIDEN NAME Katherine Carey | | 14. NAME OF HUSBAND OR WIFE Gilsen Late Alice Lorenz nee/ | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None | | 16. SOCIAL SECURITY NO. 488-01-8641 | | 17. INFORMANT Address Katherine LaRose 6463 Scanlon Av. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Coronary Occlusion - - - - - instantaneously. | | | | | | | |
| DUE TO (b) Coronary Sclerosis - - - - - | | | | | | | Abt. 2 yrs. |
| DUE TO (c) Cor Pulmonale - - - - - | | | | | | | Abt. 5 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Psychoneurosis, Anxiety reaction. | | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY | STATE |
| 21. I attended the deceased from Sept. 2, 1959 to Sept. 5, 1959 and last saw him live on Sept. 5, 1959 | | | | Death occurred at 5:20 A. M. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) John A. Brennan M.D. | | 22b. ADDRESS State Hospital No. 4 Farmington, Missouri | | 22c. DATE SIGNED 9-8-59 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE Sep. 8, 1959 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION (City, town, or county) St. Louis, Mo. | | (State) | |
| 24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway | | 25. DATE RECD. BY LOCAL REG. Sept. 8, 1959 | | 26. REGISTRAR'S SIGNATURE Gather Rudloff | | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 22 1958

NOV 18 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Edwin A. McNamee

Licensed Embalmer No. 3024

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.