

RT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. JAN 9 1961 318 Primary Registration District No. 1003 Registrar's No. 12530 -60-047680 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY City St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Length of stay in 1b LIFE	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 3225 Montgomery Ozman Shelter
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First WILLIAM Middle Last LENZ			4. DATE OF DEATH Month 12 Day 27 Year 60		
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/14/1878	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Laborer	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Frances Lenz		13b. MOTHER'S MAIDEN NAME U.K.		14. NAME OF HUSBAND OR WIFE Single	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. No.	17. INFORMANT Eleanore Salz, 203 8 A Victor St.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROBABLE CVA		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) THROMBOSIS		
DUE TO (c) ARTERIAL SCLEROSIS		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331X			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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
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21. I attended the deceased from 11/11/60 to 12/27/60 and last saw her/him alive on 12/27/60	
Death occurred at 11:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE Robert L. Bass M.D. (Degree or title)	22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 12/27/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec 29 60	23c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul	23d. LOCATION (City, town, or county) (State) St. Louis
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24. FUNERAL DIRECTOR McLaughlin 2301 Lafayette ADDRESS	25. DATE RECD. BY LOCAL REG. DEC 29 1960	26. REGISTRAR'S SIGNATURE Loan Smith Jr. V.
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

not
A. G. Ferris

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.