

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32703

State File No. \_\_\_\_\_

Registrar's No. 7455

FILED OCT 2 1952

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1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		REGISTRAR'S NO. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ Mo. b. COUNTY _____ St. Louis				
b. CITY (If outside corporate limits, write RURAL and give town) _____ St. Louis		c. LENGTH OF STAY (in this place) _____ 8 Weeks		c. CITY (If outside corporate limits, write RURAL and give township) _____ Normandy		418		
d. FULL NAME OF HOSPITAL OR INSTITUTION _____ De Paul Hospital				d. STREET ADDRESS (If rural, give location) _____ 7455 Leadale Drive				
3. NAME OF DECEASED (Type or Print) a. (First) _____ Elizabeth b. (Middle) _____ Allenberg c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) _____ Aug. 3, 1952					
5. SEX _____ Female	6. COLOR OR RACE _____ White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____ Widowed		8. DATE OF BIRTH _____ April 12, 1881		9. AGE (In years last birthday) _____ 71	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) _____ At Home		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) _____ Freeburg Ills.		12. CITIZEN OF WHAT COUNTRY? _____		
13a. FATHER'S NAME _____ John Lucash		13b. MOTHER'S MAIDEN NAME _____ Mary Iicha		14. NAME OF HUSBAND OR WIFE _____ Stephen Deceased				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____ 488-09-9440		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS _____ Miss. Bernice Allenberg Drive 7455 Leadale Drive				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ Carcinoma of rectum.					INTERVAL BETWEEN ONSET AND DEATH _____ 5-7-51		
	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. _____ none							
19a. DATE OF OPERATION _____ 5-28-51	19b. MAJOR FINDINGS OF OPERATION Diagnosis confirmed by biopsy. DePaul Hospital						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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) _____				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____ 154X				
22. I hereby certify that I attended the deceased from _____ 5-7-51, 19____, to _____ 8-3-52, 19____, that I last saw the deceased alive on _____ 8-3-52, 19____, and that death occurred at _____ 9:15 P.M., from the causes and on the date stated above.								
23a. SIGNATURE _____ Walter K. Sorenson, M.D.			23b. ADDRESS _____ 1506 St. Louis			23c. DATE SIGNED _____ 8-4-52		
24a. BURIAL, CREMATION, REMOVAL (Specify) _____ Burial		24b. DATE _____ Aug. 6, 1952	24c. NAME OF CEMETERY OR CREMATORY _____ Calvary Cemetery		24d. LOCATION (City, town, or county) (State) _____ St. Louis Mo.			
DATE REC'D BY LOCAL REG. _____ AUG 4 1952		REGISTRAR'S SIGNATURE _____ J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS _____ Arthur J. Donnelly 3840 Liddell				

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

Dr. Sporenman  
1506 S. Lewis Ave  
1-2 DR

**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 .....

Student Embalmer

Signed \_\_\_\_\_

*W. VanMatre*

Licensed Embalmer No. 2825

P. O. Address 3840 Lindell

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