

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City *St. Louis* (No. *Deaconess Hospital*)

File No. **25150**
Registered No. **6940**
St. Ward)

2. FULL NAME *Fredrick Wm Krueter*

(a) Residence. No. *1925 Newhouse* St., *26* Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. — mos. — ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Widowed

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

March 3, 1854

7. AGE

YEARS
74

MONTHS
3

DAYS
28

IF LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Janitor

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Not known

(STATE OR COUNTRY)

Germany

10. NAME OF FATHER

Carl Krueter

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Not known

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Germany

(STATE OR COUNTRY)

14.

INFORMANT (Address)

Herbert Krueter

1314 Boland

15.

FILED

11 - 3 - 1928

New Castle Ky

REGISTRAR

3

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

July - 1 - 1928

17.

I HEREBY CERTIFY, That I attended deceased from

1 - 13 - 1928, to *7 - 1 - 1928*.

that I last saw him alive on *July 1, 1928*, and that death occurred, on the date stated above, at *9 - a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7 Hemiplegia

75 W

(duration) *11.90* yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

Arterial sclerosis

Stenility

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *no.* DATE OF.....

WAS THERE AN AUTOPSY? *no.*

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) *Ralph Thompson*, M. D.

, 19 (Address) *4125 W. Belle*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

July Fordens

July 4, 1928

20. UNDERTAKER

ADDRESS

Chedney & Sons

3934 N. 20

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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