WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

FEB 28 1935

Do not use this space.

5276

1. PLACE OF DEATH
County Jackson
Township Kaw
City Kansas City (No. 613 Main St. 5C4 Ward)

Registration District No. 399
Primary Registration District No. 4002

File No.
Registered No.

2. FULL NAME Albert Krohn
(a) Residence, No. ~~613 Main~~ St., Ward. 1438 N 15 - Milwaukee Wisc
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 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): ~~Unknown~~ Divorced

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: ~~Unknown~~ Ida Krohn

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): ~~Unknown~~ Oct 12 1871

7. AGE: Approx. 6663 YEARS, MONTHS 4, DAYS 22; If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Unknown
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

FATHER
13. NAME Unknown
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Coroners Office

18. BURIAL, CREMATION, OR REMOVAL
PLACE Milwaukee, Wisc. DATE Feb. 5, 1935

19. UNDERTAKER (ADDRESS) H. Tigerman & Sons, K.C.Mo.

20. FILED 2-5, 1935 M. M. Crowe asst Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2/4/35, 19

22. I HEREBY CERTIFY That I attended deceased from ....., 19....
I last saw h.... alive on ....., 19.... Death is said to have occurred on the date stated above at ....m.
The principal cause of death and related causes of importance were as follows:

Date of onset

Primary Chromosis
Chronic Myocardial Infarction

Other contributory causes of importance:

Name of operation ..... Date of ....
What test confirmed diagnosis? ..... Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19....
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) ....., M. D.
(Address)

100M-11-24-33