

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

32644

Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
(b) Township..... Primary Registration District No. **1003**
(c) City **St Louis** (d) Street No. **1908 Ferry St** St. **St.**
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. **1908 Ferry St** St. **9** (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 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 **August Kruse**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Nov 16 1873**

7. AGE YEARS **63** MONTHS **9** DAYS **28** If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Household**
9. Industry or business in which work was done, as 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) **St Louis** (STATE OR COUNTRY) **Mo**

13. NAME **John Kassing**
14. BIRTHPLACE (CITY OR TOWN) **Germany** (STATE OR COUNTRY)

15. MAIDEN NAME **Elizabeth Unknown**

16. BIRTHPLACE (CITY OR TOWN) **Germany** (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) **Marie Kruse 1908 Ferry St.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **New Bethlehem Cem.** **Sept 17, 1937**

19. FUNERAL DIRECTOR (ADDRESS) **Beiderwieden Funeral Home, Inc. 1936 St Louis Ave**

20. FILED **SEP 17 1937** **J. F. Bruck** Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Sept 14 1937**

22. I HEREBY CERTIFY, That I attended deceased from **Sept 9, 1937, to Sept 14, 1937**
I last saw her alive on **Sept 14, 1937** Death is said to have occurred on the date stated above, at **5:15 P M**
The principal cause of death and related causes of importance were as follows:

Acute Atrial Fibrillation Date of onset **9-9-37**

Other contributory causes of importance:
Broncho-pneumonia 9-12-37
Adenoma of thyroid non malignant 1900?

Name of operation..... Date of.....
What test confirmed diagnosis? **Clinical** Was there an autopsy? **no**

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? **no**
(If so, specify.....)

(Signed) **O. E. Sykes** M. D.
(Address) **4218 N. Grand Blvd.**

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.

STATEMENT BY LICENSED EMBALMER

I, Guthatz, Licensed Embalmer No. 3737
hereby certify that the body recorded on the reverse side of this certificate was embalmed by me
L. E.
No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed Guthatz
Licensed Embalmer No. 3737

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.)