

NOV 15 1937 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

35930
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. **City Hospital No. 1** St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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. **2633 South Broadway** St. **23** (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 **male** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Divorced**

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
abt. 65

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Cabinet Maker**
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) (STATE OR COUNTRY) **St. Louis, Mo.**

13. NAME **George Krantz**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis, Mo.?**

15. MAIDEN NAME **Unknown**

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

17. INFORMANT **Hosp. Info M. Kent** (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE **St. Matthews** DATE **Oct. 13**, 19**37**

19. FUNERAL DIRECTOR **Wacker-Helderle** (ADDRESS) **2331 S. Broafway**

20. FILED **12 1937** 19 **J. W. Bredeck** Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **10/10/37**, 19**37**

22. I HEREBY CERTIFY, That I attended deceased from **10/8/37**, 19**37**, to **10/10/37**, 19**37**.

I last saw him alive on **10/10/37**, 19**37**. Death is said to have occurred on the date stated above, at **6.48 a.m.**

The principal cause of death and related causes of importance were as follows:

Cerebrospinal Meningitis (Staphylococcus aureus)
Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? 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**37**
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 **Cerebral Polio** M. D.
(Signed) **J. W. Bredeck**
(Address) **City Hospital No.**

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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STATEMENT BY LICENSED EMBALMER

I, Frank J. Hyland, Licensed Embalmer No. 2645
hereby certify that the body recorded on the reverse side of this certificate was embalmed by me
L. E.
No. 2645 or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed Frank J. Hyland
Licensed Embalmer No. 2645

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.)