

REC'D MAY 10 1938

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

13009

Do not use this space.

3613

## 1. PLACE OF DEATH

(a) County .....  
(b) Township .....  
(c) City St. Louis, Mo. (d) Street No. City Hospital #1 St. 791  
(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. 1003  
(If death occurred in Hospital or Institution, write its name instead of street and number)

## 2. PRINT FULL NAME

Robert Kreis 620  
(a) Residence, No. 1941 a Benton St. 26 (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) Widower

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8/27 - 1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
69 7 21

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Nil  
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) Iowa

13. NAME Robert Kreis

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ?

15. MAIDEN NAME Liza ?

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) ?

17. INFORMANT Hosp. info. M. Williams (ADDRESS) City Hospital #1

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Johns Cem DATE 4/19 1938

19. FUNERAL DIRECTOR (NAME) H. G. Lindsey (ADDRESS) 1417 N. Market

20. FILED APR 18 1938 J. D. Budick Local Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 4/18/38 19

22. I HEREBY CERTIFY, That I attended deceased from 3/12/38, 19, to 4/18/38, 19.

I last saw him alive on 4/18/38, 19. Death is said to have occurred on the date stated above, at 1:50 A.M.

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

Hypertensive heart disease Date of onset

Other contributory causes of importance:  
Generalized arteriosclerosis  
Senility

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) Thomas Welf, M. D.

(Address) 1515 Lafayette

**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 \_\_\_\_\_  
Registered Apprentice No. \_\_\_\_\_, working under my personal supervision

Signed \_\_\_\_\_

Licensed Embalmer No. 1674

P. O. Address \_\_\_\_\_

**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, above space should be left blank.**