

REC'D SEP 19 1939

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

29686
Do not use this space.

1. PLACE OF DEATH

(a) County Marion Registration District No. 547
 (b) Township Mason Primary Registration District No. 3029 Registered No. 343
 (c) City Hannibal (d) Street No. 114 North 7th 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 652 Carl Peter Kranz

(a) Residence, No. 114 North 7th St. (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 Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 20, 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
78 3 29

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

FATHER
 13. NAME Unknown

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

MOTHER
 15. MAIDEN NAME Unknown

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

17. INFORMANT (ADDRESS) Mrs. Krans
114 North 7th

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Mt. Olivet DATE 8/21/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Smiths' Funeral Home
Hannibal Missouri

20. FILED Aug 21 1939 W. C. Fisher Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 19 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug 17, 1939, to Aug 19, 1939

I last saw him live on Aug 19, 1939. Death is said to have occurred on the date stated above, at 7:45 P.M.
 The principal cause of death and related causes of importance were as follows:

Coronary Thrombosis

Date of onset 8-19-39

Other contributory causes of importance:

Arteriosclerosis

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

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no Date of injury no
 Where did injury occur? no (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury no
 Nature of injury no

24. Was disease or injury in any way related to occupation of deceased? no

(Signed) W. C. Fisher Registrar
 (Address) Hannibal Mo

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.

stand date

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Hannibal Mo

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.....
..... **J.J.Marsh L.E.3932** , Registered Apprentice No.....
working under my personal supervision.

Signed *Crawford Smith*
Licensed Embalmer No..... **3814**.....

P. O. Address..... **Hannibal MO.**.....

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.