

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.

Registration District No. 305

Primary Registration District No. 4184

Registrar's No. 36

1. PLACE OF DEATH:
 (a) County GASCONADE 2
 (b) City or town OWENSVILLE
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 3 1/2 YRS. years, months or days

3. (a) PRINT FULL NAME SAMUEL A. KRETER
 8. (b) If veteran, name war _____ 8. (c) Social Security No. 494-09-6668

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife ANNA H. LOEB 6. (c) Age of husband or wife if alive 47 years
 7. Birth date of deceased NOV. 28 1888
 (Month) (Day) (Year)

8. AGE: Years 51 Months 0 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace HOPE MISSOURI
 (City, town, or county) (State or foreign country)

10. Usual occupation LABORER IN MINE

11. Industry or business FIRE CLAY MINING CO

MOTHER FATHER { 12. Name EMIL KRETER
 13. Birthplace MT. STERLING MO.
 14. Maiden name MARY KAUEGER
 15. Birthplace DAY MO.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Paul J. Brossard
 (b) Address Owensville Mo.

17. (a) BURIAL (b) Date thereof 12-19-1939
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation OWENSVILLE CITY C.E.M.

18. (a) Signature of funeral director W.F. Gattuso
 (b) Address Owensville Mo.

19. (a) 12-21-39 (b) Paul J. Brossard, M.D.
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County GASCONADE
 (c) City or town OWENSVILLE
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 17
 year 1939 hour 3 minute 45 A.M.
 21. I hereby certify that I attended the deceased from 5-28-39
 _____, 19____, to 12-17, 1939;
 that I last saw him alive on 12-17, 1939;
 and that death occurred on the date and hour stated above.

Immediate cause of death Arterial Fibrillation 20 minutes

Due to Chronic Hypertension 2 yrs.

Due to Hypertension 1 yr.

Other conditions Epilepsy 24 20 yrs.

PHYSICIAN _____
 Major findings: _____
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature Paul Brossard, M.D. (M. D. or other) _____
 Address Owensville, Mo. Date signed 12-22-39

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 me

....., Registered Apprentice No.....

working under my personal supervision.

Signed W.F. Gettenstroeter

Licensed Embalmer No. 1444

P. O. Address Owensville

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.