

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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. 1003

Primary Registration District No. _____

Registrar's No. 156

1. PLACE OF DEATH: 2
 (a) County _____
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
3308 Russell Blvd.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1
 (a) State Mo. (b) County _____
 (c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
 (d) Street No. 3308 Russell Blvd.
(If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME Minnie Krabbe 610
 (b) If veteran, name war None
 (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan. day 5th
 year 1940 hour 4:45 minute A.M. M.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Kate Fred W. Krabbe
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Sept. 22 1863
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 6 1939 to Jan 5 1940
 that I last saw her alive on Jan 4 1940
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
75 3 14 _____ hr. _____ min.

Immediate cause of death
Apoplexy cerebral
 Due to Hypertension
 Due to Chronic myocarditis
 Other conditions —
(Include pregnancy within 3 months of death)

Duration
6 wks
10 wks
10 wks

9. Birthplace Belleville Illinois
(City, town, or county) (State or foreign country)
 10. Usual occupation Housewife

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

MOTHER FATHER
 11. Industry or business _____
 12. Name Unknown Frick 9
 13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
 14. Maiden name Unknown 9
 15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Irma Frances Krabbe
 (b) Address 3308 Russell Blvd.
 17. (a) Burial (b) Date thereof 1-8-40
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation OAK GROVE MALLORY

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? _____
(Specify type of place)
 (e) While at work? _____ (e) Means of injury _____

18. (a) Signature of funeral director Kriegshauser Mortuary
 (b) Address 4228 So. Kingshighway
 19. (a) JAN 7 1940
(Date received local registrar)

23. Signature J. R. Jennings (M. D. or other) MD
 Address Memphis, Tenn. Date signed 1/6/40

Dr. J. H. Finney
Humboldt City
\$3.00 to show

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

Reinhold K. Lohmann

Licensed Embalmer No.

3395

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.