

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

27564

ED SEP 5 1940
Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3197

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Home - 6410 E. 15th St. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 30 years
years, months or days

3. (a) PRINT FULL NAME Mary E. Krueger 626
8. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Robert F. Kruger 6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased May 30th, 1888
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
52 2 12 hr. min.

9. Birthplace Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

12. Name David Horn

13. Birthplace unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Robert F. Krueger

(b) Address 6410 E. 15th St.

17. (a) Burial (b) Date thereof Aug. 14th,
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mayview, Missouri

18. (a) Signature of funeral director Rose & Henderson
Kansas City.

(b) Address Kansas City.

19. (a) Aug. 12, 1940 (b) M. M. Crow
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 6410 East 15th, St.
(If rural, give location)
(e) If foreign born, how long in U. S. A. Life years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 12th,
year 1940 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from April 8, 1940 and April 12, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death necrosis of bones of leg and spine of (non tuberculous)
Due to 13 1/2
Due to 13 1/2

Other conditions no
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(c) Where did injury occur? no
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? no (Specify type of place) (e) Means of injury no

23. Signature J. F. Warkon (M. D. or other)

Address Professional Bldg Date signed 8-12

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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.

1 X19511

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

John B. Camp

Licensed Embalmer No. *2955*

P. O. Address *K.C. 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.