

No. 2
-13-40
17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 8 1941
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

43847

State File No. _____
Registrar's No. 2339

Registration District No. 784 Primary Registration District No. 200

1. PLACE OF DEATH:
(a) County ST. LOUIS
(b) City or town MANCHESTER
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
MANCHESTER NURSING HOME
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 yrs. 3 mo. 11 days
(Specify whether in this community _____ years, months or days) 2 yrs. 3 mo 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County ST LOUIS
(c) City or town Florissant
(If outside city or town limits, write "RURAL.")
(d) Street No. Mo. Balloums Rdr
(If rural, give location) 0
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME WILLIAM F. KRUSE
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased February 11, 1864
(Month) (Day) (Year)

8. AGE: Years 76 Months 9 Days 17 If less than one day _____ hr. _____ min.

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

10. Usual occupation ret, farmer

11. Industry or business _____

12. Name Carl Kruse

13. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

14. Maiden name Louisa Vogelsson

15. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Record

(b) Address ST LOUIS Co Hospital

17. (a) Removal (b) Date thereof 12-12-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis U Anatomical Board

18. (e) Signature of funeral director Walter Richter

(b) Address 3500 Rutger

19. (a) DEC 12 1940 (b) W. H. Meyer
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month NOV day 28
year 1940 hour 5 minute 20 A.M.

21. I hereby certify that I attended the deceased from June 18th, 1939 to Nov 27, 1940
that I last saw him alive on November 27, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Interstitial Nephritis

Due to _____
Due to _____

Other conditions Chronic Myocarditis
(Include pregnancy within 3 months of death) of Arterio Sclerosis

Major findings:
Of operations [Signature]
Of autopsy _____

Duration _____
PHYSICIAN _____
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 R. W. Jansen (M. D. or other) _____
Address MANCHESTER, MISSOURI Date signed 11/7/40

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

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.....

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, fact should be so stated above.