

FEB 19 1941
Registration District No. 7.73

Primary Registration District No. 6018A

Registrar's No. 26

1. PLACE OF DEATH

(a) County St. Francois

(b) City or town Rural - St. Francois Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital #4 Farmington Mo
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Months 13 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME CHARLES E. KREICHEL

3. (b) If veteran, name war No 3. (c) Social Security No. 488-10-1749

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Louise Kreichelt 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased Jan. 24 1885
(Month) (Day) (Year)

| | | | | |
|---------|-----------|----------|-----------|----------------------------|
| 8. AGE: | Years | Months | Days | If less than one day |
| | <u>56</u> | <u>1</u> | <u>20</u> | <u>—</u> hr. <u>—</u> min. |

9. Birthplace St. Louis Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Office worker

11. Industry or business Manufacturing

12. Name Charles E. Kreichelt

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

14. Maiden name Katherine Albrecht

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

16. (a) Informant Records State Hospital No. 4

(b) Address Farmington, Missouri

17. (a) BURIAL (b) Date thereof FEB-15-1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MT. LEBANON C.E.M.

18. (a) Signature of funeral director Parker Lind Co.

(b) Address WEBSTER GROVES MO.

19. (a) 1-13-41 (b) B. E. Robinson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County PHELPS

(c) City or town Cuba
(If outside city or town limits, write "RURAL")

(d) Street No. Rural Route #3
(If rural, give location)

(e) If foreign born, how long in U. S. A. — years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 13th
year 1941 hour 10 minute 45 A. M.

21. I hereby certify that I attended the deceased from 10-29-40
to 2-13-41, 19____, to 2-13-41, 19____;
that I last saw him alive on 2-12-41, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death General paralysis of Insane (paris) 2+ yrs

Due to Cerebral Hemorrhage (Nov 1940)
Chronic myocarditis (apoplectic?)
Chronic arteriosclerosis (renal)
Chronic nephritis

Major findings: no

Of operations no

Of autopsy no

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 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? _____

(Specify type of place) _____
(e) Manner of injury _____

23. Signature [Signature] (M. D. Other) _____
Address _____ Date signed _____

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

94
0
0

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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 Bob Aldrich

Licensed Embalmer No. 1332

P. O. Address Debesteys Hwy in

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.