

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18985

JUN 6 1941
Registration District No. 104784

Primary Registration District No. J0D

Registrar's No. 1162

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

2600

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Carondelet Krebs
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Koch Hospital (1)
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 yrs, 5 mo, 13 days
(Specify whether years, months or days)

In this community 21 years

3. (a) PRINT FULL NAME BARBARA KREBS

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased FEB. 8, 1894
(Month) (Day) (Year)

8. AGE: Years 47 Months 3 Days 23 If less than one day hr. _____ min. _____

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

10. Usual occupation OFFICE WORK

11. Industry or business _____

MOTHER { 12. Name JOSEPH KREBS

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

14. Maiden name MARGARET WULMERT

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

16. (a) Informant KOCH HOSP. RECORDS

(b) Address KOCH, MO.

17. (a) BURIAL (b) Date thereof 6/4/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation OLD ST. PETER'S PAUL

18. (a) Signature of funeral director Sakumacher

(b) Address 3013 Duquesne

19. (a) JUN - 3 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County 000

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 3521 CHEROKEE 9
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 8
year 1941 hour 7:15 minute A. M.

21. I hereby certify that I attended the deceased from 12-18, 1929, to 6-1, 1941;
that I last saw her alive on 6-1, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis 18 yrs?

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 136

Of operations _____

Of autopsy _____

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 Bernard Friedman (M. D. or other) M.D.

Address Koch Hospital, Koch, Mo. Date signed 6-2-41

DEC 12 1945

OCT 13 1944

MAY 16 1946

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.....

George J. Archambault....., Registered Apprentice No.....
working under my personal supervision.

Signed

George J. Archambault

Licensed Embalmer No. 2906

P. O. Address 3013 Myrtle

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.