

S. No. 2
M-5-42
7-5-17-39

22648

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUL 9 1943
Registration District No. 360

Primary Registration District No. 3076

Registrar's No. 54

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

1. PLACE OF DEATH:

(a) County Demon
(b) City or town Nevada Mo.
(c) Name of hospital or institution
619 E Locust 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community 9 mo. (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Demon
(c) City or town Nevada
(d) Street No. 619 E Locust
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME

Joseph F. Krapner

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex Male 5. Color or face White

6. (a) Single, widowed, married, divorced..... 9-

6. (b) Name of husband or wife
Ruth Lillian Krapner

6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased man 4 1979
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 2 29 hr. min.

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

10. Usual occupation Retired Fireman

11. Industry or business K.C.V. Fireman

MOTHER FATHER

12. Name Michel Krapner

13. Birthplace Austria 4
(City, town, or county) (State or foreign country)

14. Maiden name Ema Jantz
(City, town, or county) (State or foreign country)

15. Birthplace Austria 4
(City, town, or county) (State or foreign country)

16. (a) Informant Ruth Lillian Krapner

(b) Address Nevada Mo.

17. (a) Funeral (b) Date thereof 6-4-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Joseph

18. (a) Signature of funeral director John Thomas Hale
(b) Address Kansas City Kansas

19. (a) 6-3-43 (b) Bozell B. Bewick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 3
year 1943 hour 7:45 min. am

21. I hereby certify that I attended the deceased from May
14 1943 to June 3 1943
that I last saw h. im alive on May 29 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to IBD

Other conditions Cerebral Apoplexy abd.
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy none

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 Wm H. Allen (M. D. or other) Mo.
Address Nevada, Mo. Date signed 6-3-43

Duration
?

PHYSICIAN

Underline the cause to which death should be charged statistically.

116 1/2 west walnut
Berwick

RECEIVED
District Health Officer No. 7,
District File Number 6-43-666
Date Filed 7-8-43

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..... W. J. Ward
Licensed Embalmer No. 3991
P. O. Address 309 E. 67th St.

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.