

Registration District No. **NOV 8 1943 226**

Primary Registration District No. **5801**

Registrar's No. **53**

**1. PLACE OF DEATH:**  
(a) County **Monroe**  
(b) City or town **Rural Washington Township**  
(c) Name of hospital or institution: **Hunnnewell R.F.D.2**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **20 Years** (Specify whether years, months or days) **1**

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State **Missouri** (b) County **Monroe 069**  
(c) City or town **Rural 0**  
(If outside city or town limits, write "RURAL") **1**  
(d) Street No. **Hunnnewell 110 R.F.D.2**  
(If rural, give location)  
(e) Citizen of foreign country? **NO** (Yes or No) **1**  
If yes, name country.

**3. (a) PRINT FULL NAME** **Randolph J. Krummel**  
**3. (b) If veteran, name war** **None** **3. (c) Social Security No.** **None**

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH:** Month **October** day **28th** year **1943** hour **II** minute **A.** M.

**4. Sex** **Male C** **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

**21. I hereby certify that I attended the deceased from** **Oct 15 1943** to **Oct 28 1943**  
that I last saw him **alive on Oct 15 1943**  
and that death occurred on the date and hour stated above.

**7. Birth date of deceased** **January 15 1880**  
(Month) (Day) (Year)  
**8. AGE:** Years **63** Months **9** Days **13** If less than one day hr. min.

Immediate cause of death **cardiac failure**  
**Chronic appendicitis and myofasciitis**  
Due to **Chronic appendicitis and myofasciitis**  
Due to **Chronic appendicitis and myofasciitis**

**9. Birthplace** **Marion County Missouri**  
(City, town, or county) (State or foreign country)  
**10. Usual occupation** **Farmer**

Other conditions (Include pregnancy within 3 months of death) **9301**  
Major findings: Of operations **none**  
Of autopsy **none**

**11. Industry or business**  
**12. Name** **Justus Krummel**  
**13. Birthplace** **D.K. Germany**  
(City, town, or county) (State or foreign country)  
**14. Maiden name** **Marie Shaffer**  
**15. Birthplace** **D.K. Germany**  
(City, town, or county) (State or foreign country)

**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?

**16. (a) Informant** **Harold Krummel**  
**(b) Address** **Monroe City Mo**  
**17. (a) Burial** **Monroe City Mo** **(b) Date thereof** **10/31/43**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
**(c) Place: burial or cremation** **St. Junes Monroe City**  
**18. (a) Signature of funeral director** **Wils. & Sons**  
**(b) Address** **Monroe City Mo**  
**19. (a) Oct 29 - 43** **(b) Oth. Hedberg**  
(Date received local registrar) (Registrar's signature)

**23. Signature** **Vellis G. Christman M.D.**  
**Paris, Mo** **Date signed** **10-28-43**  
While at work? (Specify type of place) (b) Means of injury.

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 11-43-17-55

Date Filed NOV 5 1943

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 For me

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Lucie L. Wilson

Licensed Embalmer No. 3014

P. O. Address Waukegan, Ill.

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.