

FILED DEC 22 1943

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10899**

1. PLACE OF DEATH:

(a) County **St. Louis**
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 day**
(Specify whether
In this community **47 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **17**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3920 Shenandoah**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Arthur William Kruse**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **494-05-3770**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**

(b) Name of husband or wife **Florence Wilkinson Kruse** (c) Age of husband or wife if alive **58** years

7. Birth date of deceased **May 3rd. 1883**
(Month) (Day) (Year)

8. AGE: Years **60** Months **7** Days **6** If less than one day
hr. min.

9. Birthplace **Washington Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Painter**

11. Industry or business **House Painting**

12. Name **George Kruse**

13. Birthplace **Warren County Missouri**
(State or foreign country)

14. Maiden name **Emilia Quickert**
(State or foreign country)

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

16. (a) Informant **Florence Kruse**

(b) Address **3920 Shenandoah**

17. (a) **Burial** (b) Date thereof **Dec. 11th 1943**
(Specify type of place) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peter's Cemetery**

(d) Signature of funeral director **Henry Schneider**

(b) Address **6203 Gravois Ave.**

19. (a) **DEC 10 1943** (b) **J. F. Bredbeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **9th**
year **1943** hour **3** minute **30 AM**

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Broncho Pneumonia
primary

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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)

23. Signature **Thomas F. Callahan** (M. D. or other)

Address **Deputy Coroner** Date signed **12-10-43**

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....
.....
working under my personal supervision.

Registered Apprentice No.....

Signed..... *Albert G. Hoffe*

Licensed Embalmer No..... *2971*

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.