

FILED FEB 18 1944

613

Registration District No. _____ Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____
 (b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
716 N. Taylor Ave.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community **28 Years** (Specify whether
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
 (c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
 (d) Street No. **716 N. Taylor Ave.**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Joseph E. Kreusch**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. **193-07-8117**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **7**
 year **1944** hour **12** minute **35** A. M.

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Ida** 6. (c) Age of husband or wife if
 alive **60** years
 7. Birth date of deceased **FEB. 22 1883**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
Dec. 3, 1940, to **Feb. 6, 1944**
 that I last saw him alive on **Feb. 6, 1944**
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	60	11	15	hr. min.

Immediate cause of death **Chronic myocarditis**
 Due to **Dilated cardiomyopathy**
 Due to _____
 Other conditions **U**
(Include pregnancy within 3 months of death)

9. Birthplace **Illinois**
(City, town, or county) (State or foreign country)
 10. Usual occupation **Retired Dry Goods Salesman Wholesale**
 11. Industry or business _____
 12. Name **Matt Kreusch**
 13. Birthplace **FRANCE**
(City, town, or county) (State or foreign country)
 14. Maiden name **Anna Heidrich**
 15. Birthplace **Alcuse**
(City, town, or county) (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER {
 16. (a) Informant **Mrs. Ida Kreusch**
 (b) Address **716 N. Taylor Ave**
 17. (a) **Burial** (b) Date thereof **2-9-44**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Calvary Cemetery**
 18. (a) Signature of funeral director **Arthur Donnelly**
 (b) Address **3840 Leideff Blvd**
 19. (a) **FEB 9 1944** (b) **J. F. Bradeck**
(Date received local registrar) (Registrar's signature)

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 **S**
 23. Signature **Newton John Everell** (M. D. or other) **MD.**
 Address **4129 Washington Blvd** Date signed **2/7/44**

4129 West

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 H Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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.