

FILED APR 28 1944

Registration District No. 370Primary Registration District No. 3058Registrar's No. 52

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME

Mrs. Elizabeth Krohne

3. (b) If veteran, name war _____
 3. (c) Social Security No. None

4. Sex Female / 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed

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

7. Birth date of deceased February 3, 1873
 (Month) (Day) (Year)

8. AGE: Years 71 Months 1 Days 0
 If less than one day _____ hr. _____ min.

9. Birthplace Portage Des Sioux, Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

12. Name A. P. Anderson
 13. Birthplace Portage Des Sioux, Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant John Anderson
 (b) Address St. Charles County, Mo
 17. (a) Burial (b) Date thereof Mar. 6, 1944
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St. Johns Cemetery

18. (a) Signature of funeral director Naeflyman - Baum
 (b) Address 326 N. 6th St. St. Charles, Mo
 19. (a) March 6, 1944 (b) Ernst G. Paul
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles
 (c) City or town St. Charles
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1411 N. Second Street
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3
 year 1944 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw her alive on March 3, 1944,
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis & excretory collapse
 Due to post-choleralectomy ✓ 3/2/44

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: No
 (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 George Steile (M. D. or other) MD
 Address St. Char. Mo. Date signed 3/4/44

JUN 5 1944

RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 4. 27. 44

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 _____

Licensed Embalmer No. 3155

P. O. Address St Charles Mo

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.