

FILED JUN 3 1944

Registration District No. _____

Primary Registration District No. **1003**

Registrar's No. **4971**

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: **4324a Grace Ave. /**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: **000**

(a) State **Missouri** (b) County **St. Louis**

(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **4324a Grace Ave.**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **Herman J. Krull**

3. (b) If veteran, name war _____

3. (c) Social Security No. **319-03-6313**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **27**
year **1944** hour **12** minute **45 P.M.**

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Mary** 6. (c) Age of husband or wife if alive **55** years **1896**

7. Birth date of deceased: **Jan.** (Month) **22** (Day) **1896** (Year)

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death: **Coronary Occlusion Arteriosclerosis**

8. AGE:	Years	Months	Days	If less than one day
	48	4	5	hr. _____ min. _____

Due to _____

Due to **94**

9. Birthplace: **St. Louis Mo.**
(City, town, or county) (State or foreign country)

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

10. Usual occupation **Credit Man**

11. Industry or business **Armour & Co.**

Major findings: _____

Of operations _____

Of autopsy _____

MOTHER FATHER

12. Name **John Krull**

13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant **Mary Krull**
(b) Address **4324a Grace Ave.**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) **Burial** (b) Date thereof **May 31, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New S S Peter & Paul Cem.**

(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? _____

18. (a) Signature of funeral director **Walter Kaldere**
(b) Address **3634 Gravois Ave.**

While at work? _____
(Specify type of place)

(e) Means of injury **3**

19. (a) **MAY 30 1944** (b) **J. F. Bredek**
(Date received local registrar) (Registrar's signature)

23. Signature **Thomas J. Callahan** (M. D. or other) _____
Address **Deputy Coroner** Date signed **5-29-44**

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

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 Robert C. Wheeler

Licensed Embalmer No. 2178

P. O. Address W. Louisiana

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.