

FILED SEP 8 1944

Registration District No. 318

Primary Registration District No. 1003

State File No. _____

Registrar's No. _____

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:
Alexian Brothers Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 Days
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Robert Thomas Krull

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 27 years (Day) (Year)

7. Birth date of deceased April 27 1917
(Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|----------|----------------------|
| | <u>23</u> | <u>4</u> | <u>5</u> | hr. _____ min. |

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name Henry B. Krull

13. Birthplace Gildehaus, Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Mary Uhlen

15. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Henry B. Krull

(b) Address 3006 Osage St.

17. (a) Burial (b) Date thereof 9/5/1944
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Gebken-Benz Mortuary

(b) Address 2842 Meramec St.

19. (a) SEP 4 1944 (b) J. Biedenk
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 17 15

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

(d) Street No. 3006 Osage St.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 1
year 1944 hour 7 minute 05 P. M.

21. I hereby certify that I attended the deceased from 8-27, 1944, to Sept 1, 1944
that I last saw him alive on Sept 1, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Embolism

Duration sudden

Due to _____

Due to _____

Other conditions Pulmonary Abscesses
(Include pregnancy within 3 months of death) non-tubercular

Major findings: Of operations _____

Of autopsy yes - above

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 _____

23. Signature Joseph L. Slus (M. D. or other) _____

Address 405 S. ... Date signed 9/2/44

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

MOTHER FATHER

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..... *Howard F. Rowland*

Licensed Embalmer No..... *3114*

P. O. Address..... *4356 Washington*

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.