

FILED OCT 6 1944

State File No. _____

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8358

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:
St. Anthony Hospital,
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 Days.
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County wa.

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

(d) Street No. 4371 Itaska St.,
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Charles J. Kriegesman,

MEDICAL CERTIFICATION

3. (b) If veteran, name war _____

3. (c) Social Security No. 488-07-1689

20. DATE OF DEATH: Month Sept. day 28th
year 1944 hour 7: minute 15 P.M.

4. Sex Male, 5. Color or race White,

6. (a) Single, widowed, married, divorced, Widowed

21. I hereby certify that I attended the deceased from 4-22, 1939, to 9-28, 1944.
that I last saw h. live on Sept 28, 1944.
and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife Frances,

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 8 1874
(Month) (Day) (Year)

Immediate cause of death. Hypostatic Pneumonia 4 days

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>2</u>	<u>20</u>	hr. _____ min.

Due to P.O. Gastro-intestotomy 29 days

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

Due to _____

10. Usual occupation Packer

Other conditions none
(Include pregnancy within 3 months of death)

11. Industry or business Aloes Optical Co.

Major findings: Complete stricture of Duodenum - gastroenterostomy

12. Name John Kriegesman,

Of operations _____

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

Of autopsy none

14. Maiden name Don't Know,

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

15. Birthplace Don't Know,
(City, town, or county) (State or foreign country)

16. (a) Informant Edwin C. Kriegesman,
(b) Address 4371 Itaska St.

17. (a) Burial, (b) Date thereof 10/2/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director Gebken-Benz Mortuary
2842 Meramec St.,
(b) Address _____

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

(a) Accident, suicide, or homicide (specify) no

(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) (c) Means of injury _____

19. (a) OCT 1 1944 (b) J. Z. Bredek
(Date received local registrar) (Registrar's signature)

23. Signature H. J. Shelton MD (M. D. number) MD
Address 4703 Virginia Date signed 9-29-44

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

W E Morris

Licensed Embalmer No.

3360

P. O. Address

605 Boonecke Ct

Lemay, 23 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.