

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSFILED OCT 20 1944
818STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

32499

Registration District No.

Primary Registration District No.

1003

Registrar's No.

8547

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:
Jewish Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 12 weeks
 (Specify whether D)
 In this community.....
 years, months or days)

3. (a) PRINT FULL NAME FRED W. KROHNE

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Vivian D. Krohne nee Sanders 6. (c) Age of husband or wife if alive 64 years
 7. Birth date of deceased August 24, 1878
 (Month) (Day) (Year)

- | 8. AGE: | Years | Months | Days | If less than one day |
|---------|-----------|----------|-----------|----------------------|
| | <u>66</u> | <u>1</u> | <u>12</u> |hr.min. |

9. Birthplace Farina Ills.
 (City, town, or county) (State or foreign country)

10. Usual occupation Maintenance man

11. Industry or business Jewish Hospital

12. Name Henry Krohne
 13. Birthplace Unknown Germany
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary Wilke
 15. Birthplace Unknown Ills.
 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Vivian D. Krohne
 (b) Address 10046 Stimson Dr. R.G.
 17. (a) Burial (b) Date thereof ✓
 (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation Memorial Park Cemetery
 18. (a) Signature of funeral director Math Hermann & Son
 (b) Address 2161 East Fair Ave

19. (a) OCT 7 1944 (b) J. F. Bredeck
 (Date received for registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County St. Louis
 (c) City or town Riverview Gardens
 (If outside city or town limits, write "RURAL")
 (d) Street No. 10046 Stimson Dr.
 (If rural, give location)
 (e) Citizen of foreign country? ✓ (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 6
 year 1944 hour 3 minute 40 A.M.

21. I hereby certify that I attended the deceased from 7/13, 1944 to 10/6, 1944
 that I last saw him alive on 10/6, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic lymphatic leukemia 6 mo. +

Due to.....
 Due to.....

Other conditions Chronic bronchitis
 (Include pregnancy within 3 months of death)

pulmonary emphysema
 Major findings:
 Of operations.....

Of autopsy.....

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?
 (Specify type of place)
 While at work?..... (e) Means of injury.....

23. Signature David Feldman (M. D. or other) MD.
 Address Jewish Hospital Date signed 10/6/44

(Licensed Embalmer's Statement on Reverse Side)

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 *Harold A. Bennett*.....

Licensed Embalmer No. *4209*.....

P. O. Address *W. Paris, 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.