

FILED DEC 29 1945

Registration District No. **317**

Primary Registration District No. **6076**

Registrar's No. **2986**

1. PLACE OF DEATH:
 (a) County **St. Louis**
 (b) City or town **Jefferson Barracks**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Veterans Administration Hospital**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **87 days**
(Specify whether years, months or days)
 In this community **47 years**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **020**
 (c) City or town **St. Louis** **17**
(If outside city or town limits, write "RURAL")
 (d) Street No. **700-A North 3rd,** **9**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **KRILL, Frank P.**
 (b) If veteran, name war **World II**
 (c) Social Security No. **486 12 4340**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **December** day **24**
 year **1945** hour **4:40** minute **P. M.**

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Divorced**
 (b) Name of husband or wife **Mary** (c) Age of husband or wife if alive **--** years
 7. Birth date of deceased **March 13 1897**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **September 28, 1945** to **December 24, 1945**
 that I last saw him alive on **December 24, 1945**
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	48	9	11	hr. min.

Immediate cause of death **EMPHYSEMA, CHRONIC, LEFT CHEST.** **1 year**
 Duration

9. Birthplace **St. Louis Missouri**
(City, town, or county) (State or foreign country)
 10. Usual occupation **Truck Driver**
 11. Industry or business **--**

Due to **--**
 Due to **--**
 Other conditions **--**
(Include pregnancy within 3 months of death)

MOTHER {
 12. Name **Pais Krill**
 13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
 14. Maiden name **Catherine Klein**
 15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

PHYSICIAN
 Major findings:
 Of operations **Thoracoplasty, left February 15, 1945**
 Of autopsy **No autopsy**
 Underline the cause to which death should be charged statistically.

FATHER {
 16. (a) Informant **Clinical Clerk, Vet. Adm. Hosp.**
 (b) Address **Jefferson Barracks, Mo.**
 17. (a) **Burial** (b) Date thereof **12 28 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **National Cemetery Jefferson Barracks**
 18. (a) Signature of funeral director **Max H. ...**
 (b) Address **3634 Grand Ave**
 19. (a) **12-29-45** (b) **W. S. ...**
(Date received local registrar) (Registrar's signature)

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? **Harvey E. Sisk** **12/26/45**
(Specify type of place) (Means of injury)
 23. Signature **HARVEY E. SISK, M.D.** (M. D. or other) **M.C.**
 Address **Vet. Adm. Hosp. Jeff. Brks. Mo.** Date signed **12/26/45**

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 Cloherty*

Licensed Embalmer No. *2178*

P. O. Address *St. Paul*

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.