

Registration District No.

Primary Registration District No.

3010

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Southeast Missouri Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 24 days
(Specify whether
In this community 59 years
years, months or days)

3. (a) PRINT FULL NAME Fred Christian Kruse

3. (b) If veteran, name war _____ 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 Mary Kruse 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Feb. 9. 1872
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 3 6 hr. min.

9. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER { 12. Name Fred H. Kruse
13. Birthplace Unknown
14. Maiden name Elizabeth Neiderhouse
15. Birthplace Unknown Germany
(City, town, or county) (State or foreign country)

16. (a) Informant Mary Kruse

(b) Address Dexter, Missouri

17. (a) Burial (b) Date thereof 5-19-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hill Cemetery

18. (a) Signature of funeral director Strickland-Rainey

(b) Address Dexter, Missouri

19. (a) 5-24-1946 (b) B.G. Summers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard 103
(c) City or town Dexter
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15
year 1946 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from 4-22-46 to 5-15-46
and that I last saw him alive on 5-15-46
and that the death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolism Duration _____
Due to Chronic myocarditis

Other conditions Hypertrophy of Prostate
(Include pregnancy within 3 months of death)

Major findings: Of operations Hypertrophy of Prostate PHYSICIAN _____
Of autopsy A 3-d
Underline the cause to which death should be charged statistically.

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 Paul H. Summers (M. D. or other) MD
Address Cape Girardeau, Mo Date signed 5-22-46

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

RECEIVED

Health Officer No. 4

License Number 646-2193

DATE

6-6-46

9061 8 89W

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..... *J. E. Strickland*
.....
Licensed Embalmer No. 3479
P. O. Address *Weymouth, Md.*

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.