DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED AUG 30 1946

State File No. 26647

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 203

823

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

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Jefferson City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Marys Hospital 0
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole 060

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 2711 South 59th /St. 9
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 1

If yes, name country 1

3. (a) PRINT FULL NAME Mary Kroll

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Adolph

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

7. Birth date of deceased Sept. 19 1872 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
74	10	22	hr. min.

9. Birthplace Toas, Mo. Cole Co. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name John Sanning 4
13. Birthplace Germany
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Adline Bruenning
15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Jake Propst

(b) Address St. Louis, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/46 (Month) (Day) (Year)

(c) Place: burial or cremation Toas, Mo. Cemetery

18. (a) Signature of funeral director Victor Bruscher

(b) Address Jefferson City, Mo.

19. (a) 8-28-46 (Date received local registrar) (b) R.P. Dorris MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 27 year 1946 hour 9 minute 7 30 A M.

21. I hereby certify that I attended the deceased from Aug, 1922 to 8/27/46, 1946 that I last saw him alive on 8/27/46, 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Cerebral hemorrhage

Due to Fract L hip

Other conditions Hypertension
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy no

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

PHYSICIAN

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?
(Specify type of place)

While at work? (e) Means of injury 0

23. Signature M R Alfredo (M. D. or other)

Address Jefferson City Mo Date signed 8/27/46

68

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number 8-46-237
Date Filed 8-29-46

OCT 2 1946

SEP 25 1946

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 Victor Buescher

Licensed Embalmer No. 3701

P. O. Address Jefferson City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 203

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Jefferson city
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(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

3. (a) PRINT FULL NAME Mary Krall

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept (Month) 19 (Day) 18 (Year)

8. AGE: Years 74 Months 10 Days 22 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 27
year 1946 hour minute M.

21. I hereby certify that I attended the deceased from
, 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Pneumonia

Due to following fall fract hip
fall caused by cerebral hemorrhage

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 18 60 18

PHYSICIAN
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) fall at home

(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 M R Aldridge (M. D. or other)

Address Jefferson City Mo Date signed 9/4/46

SUPPLEMENTARY

25493

200647