

3. No. 2
-12-45
5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35313

State File No. _____

FILED SEP 21 1946
918

Registration District No. _____

Primary Registration District No. _____

1003

Registrar's No. 8773

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:
ENROUTE TO CITY HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5801 S. Broadway
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Krenning

3. (b) If veteran, name war no 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 Alvina Krenning 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 7 1888
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>58</u>	<u>3</u>	<u>5</u>	hr. _____ min. _____

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

10. Usual occupation Laborer

11. Industry or business Durachrome Corp.

MOTHER FATHER

12. Name Unknown 9

13. Birthplace Unknown 1
(City, town, or county) (State or foreign country)

14. Maiden name Unknown 9

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

16. (a) Informant Alvina Krenning

(b) Address 5801 S. Broadway

17. (a) Burial (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lutheran Cem. St. Charles, Mo.

18. (a) Signature of funeral director C. Hoffmeister U. & L. Co.

(b) Address 7814 S. Broadway

19. (a) OCT 13 1946 (b) J. T. Beedick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 12
year 1946 hour 9 minute a. M.

21. I hereby certify that I attended the deceased from 1 1/2 hours 195 to 2 1/2 Sept 1946
that I last saw him alive on 4 Oct 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 5 min
Due to in a malignant Hypertension Signa.

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

Major findings: 8/3
Of operations _____
Of autopsy _____

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 1
Signature Michael L. Bantock (M. D. or other) M.D.
Address 7629 So. Broadway Date signed 11 Oct 46

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

OCT 13 1946

(Licensed Embalmer's Statement on Reverse Side)

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 *Louis E. Hoffmeister*.....

Licensed Embalmer No. *3871*.....

P. O. Address *7814 S. Broadway*.....

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.