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FILED DEC 31 1946
Registration District No. **274**

Primary Registration District No. **3056**

Registrar's No. **270**

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town mobely

(c) Name of hospital or institution: Woodland Hospital
(If not in hospital or institution, write street number of 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 Missouri (b) County Randolph

(c) City or town mobely
(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 James V. Kroner

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 S. V

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Dec 19th 1946
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
		<u>3</u>	hr. min.

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

10. Usual occupation ✓

11. Industry or business _____

MOTHER FATHER

12. Name Herbert Kroner

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

14. Maiden name Lillian A. Drescher

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

16. (a) Informant Herbert Kroner

(b) Address R. D. D. Mobely Mo

17. (a) Burial (b) Date thereof Dec 23-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mobely Mo

18. (a) Signature of funeral director Mahon and Son

(b) Address Mobely Mo

19. (a) Dec 23-46 (b) Seab D. Williams
(Date received local health officer's report) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22nd
year 1946 hour _____ minute 15 a.m.

21. I hereby certify that I attended the deceased from Dec 19
1946, to Dec 22, 1946

that I last saw him alive on Dec 21, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death I do not know

Due to _____

Due to _____

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

PHYSICIAN

Major findings:
Of operations 200

Of autopsy _____

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 C. Smith (M. D. or other) _____
Address Mobely MO Date signed 12/24/46

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

RECEIVED
District Health Officer No. 10
District File Number 12-46-2345
DEC 30 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..... *Frank W DeWitt*
Licensed Embalmer No. 3071
P. O. Address..... *Mobley Ind*

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.