

**FILED FEB 10 1947**  
Registration District No. 47

Primary Registration District No. 5757

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

1. PLACE OF DEATH: CALLAWAY  
(a) County CALLAWAY  
(b) City or town STEEDMAN Ambassador  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: RURAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community LIFE years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Callaway  
(c) City or town Rural - Ambassador  
(If outside city or town limits, write "RURAL")  
(d) Street No. R#1 Steedman  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MAGGIE M. Krebs  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 1 day 25 year 47 hour 8 minute 15 A.M.  
21. I hereby certify that I attended the deceased from 1/25, 1947, to 7:45 am 1/25/47  
that I last saw him alive on 1-25, 1947  
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race White 6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife JOHN KREBS 6. (c) Age of husband or wife if alive 81 years  
7. Birth date of deceased: FEB. 15 1873  
(Month) (Day) (Year)

Immediate cause of death: Cerebral Hemorrhage  
Due to Cardio-Vascular Hypertension  
Due to Arteriosclerosis  
Other conditions: Chronic Arthritis  
(Include pregnancy within 3 months of death)  
Deformities

8. AGE: Years 73 Months 11 Days 7 If less than one day hr. min.  
9. Birthplace BURKINGTON IA.  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife

Major findings: 93D  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER, FATHER { 11. Industry or business \_\_\_\_\_  
12. Name UNKNOWN MALCOLM  
13. Birthplace SWITZERLAND  
(City, town, or county) (State or foreign country)  
14. Maiden name MARY BURRE  
15. Birthplace SWITZERLAND  
(City, town, or county) (State or foreign country)  
16. (a) Informant JOHN KREBS  
(b) Address STEEDMAN MO  
17. (a) BURIAL (b) Date thereof JAN. 27 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation STEEDMAN, MO  
18. (a) Signature of funeral director Wm. J. Mann  
(b) Address 712 CO. ST. S. Fulton, Mo  
19. (a) JAN 27-1947 (b) JOHN M. MANN  
(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) \_\_\_\_\_  
(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 W. O. Payne (M. D. or other) \_\_\_\_\_  
Address R#6 Fulton Date signed 1/27/47

Date Filed 2-7-47

District File Number \_\_\_\_\_

District Health Officer No. 9, \_\_\_\_\_

RECEIVED

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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 Glen Y. Mauhin

Licensed Embalmer No. 12725

P. O. Address Fulton, Mo.

**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.**