

FILED FEB 25 1947

State File No. _____

Registration District No. _____

Primary Registration District No. 5595

Registrar's No. 6

1. PLACE OF DEATH:

(a) County: JEFFERSON
(b) City or town: RURAL ROCK TOWNSHIP
(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 4 YEARS
years, months or days)

3. (a) PRINT FULL NAME: FRANK KRENN

3. (b) If veteran, name war: _____ 3. (c) Social Security No: 491-12-5504

4. Sex: MALE 5. Color or race: W 6. (a) Single, widowed, married, divorced: MARRIED

6. (b) Name of husband or wife: MAUDE KRENN 6. (c) Age of husband or wife if alive: 49 years

7. Birth date of deceased: JULY 27 1898 (Month) (Day) (Year)

8. AGE: Years 58 Months 6 Days 19 If less than one day hr. min.

9. Birthplace: FURSTFELD STIER MARK AUSTRIA (City, town, or county) (State or foreign country)

10. Usual occupation: MEAT CUTTER

11. Industry or business: " "

12. Name: FRANK KRENN

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

14. Maiden name: CECILIA WIRCH

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

16. (a) Informant: MAUDE KRENN

(b) Address: KIMMSWICK MO R.R. 2

17. (a) BURIAL (b) Date thereof: FEB 18 1947 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: VALHALLA CEMETERY

18. (a) Signature of funeral director: HELIOTAG FUNERAL HOME

(b) Address: KIMMSWICK MO R.R. 2

19. (a) FEB 17 47 (b) Phil G. Kirk (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: MO (b) County: JEFFERSON 50

(c) City or town: RURAL (If outside city or town limits, write "RURAL") 0

(d) Street No.: NEAR ANTONIA MO (If rural, give location) 0

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

If yes, name country: Austria, Firstfeld Stier Mark

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: FEB day: 16 year: 1947 hour: 3 minute: A.M.

21. I hereby certify that I attended the deceased from: Jan 1946 to Feb 16 1947

that I last saw him alive on: FEB 15 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Acute Cardiac Dilatation 1 day

Due to: Mitral Stenosis 9 year

Due to: Chronic Myocarditis 9

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations: ✓

Of autopsy: ✓

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) (c) Means of injury: ✓

23. Signature: Phil G. Kirk (M. D. or other)

Address: Barmhart MO Date signed: 2/17/47

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

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

MAR 20 1947

RECEIVED
District Health Officer No. 9,
District File Number ~~2-25-47~~
Date Filed ~~2-25-47~~

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 Elmer A. Eligtag

Licensed Embalmer No. 3571

P. O. Address _____

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.

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