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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. 11143

FILED APR 31 1947

Registration District No. ____ Primary Registration District No. 1003 Registrar's No. 3442

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 109
(c) City or town Wright City
(If outside city or town limits, write "RURAL")
(d) Street No. ____ (If rural, give location) RR
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME William Henry Krome
3. (b) If veteran, name war None
3. (c) Social Security No. 494-10-4746
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Manie Krome
6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased November (Month) 26 (Day) 1876 (Year)
8. AGE: Years 70 Months 4 Days 5 If less than one day ____ hr. ____ min.
9. Birthplace Wright City (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Retired Salesman
11. Industry or business ____
MOTHER FATHER
12. Name Fred Krome
13. Birthplace Unknown (City, town, or county) Germany (State or foreign country)
14. Maiden name Carrie Horstman
15. Birthplace Warren County (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Mrs. Manie E. Krome
(b) Address Wright City, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/2/47 (Month) (Day) (Year)
(c) Place: burial or cremation Wright City, Missouri
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) MAR 31 1947 (Date received local registrar) (b) ____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31 year 1947 hour 5 minute 15 A.M.
21. I hereby certify that I attended the deceased from 3-22-47, 19__, to 3-31-47, 19__; that I last saw h. — alive on 3/31-47, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion — Duration
Due to Arteriosclerosis General — Duration
Due to Hypertension — Duration
Other conditions (Include pregnancy within 3 months of death) — Duration
Major findings: Of operations ____ — Duration
Of autopsy ____ — 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 ____
23. Signature R K Carrow (M. D. or other) 3/31-47
Address 4733 Maryland Date signed ____

(Licensed Embalmer's Statement on Reverse Side)

MAY 15 1944
SEP 17 1944
AUG 26 1944

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.....

Licensed Embalmer No.....

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.