

No. 2
12-45
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 17 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20351

State File No. _____

Registration District No. 41

Primary Registration District No. 3012

Registrar's No. 87

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Excelsior Springs
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Ball Sanitarium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks
(Specify whether years, months or days)

In this community 2 weeks
(Specify whether years, months or days)

3. (a) PRINT FULL NAME George Charles Krouse

3. (b) If veteran, name war 1

3. (c) Social Security No. None

4. Sex M 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Helen I. Krouse

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased March 5 1879
(Month) (Day) (Year)

8. AGE: Years 68 Months 2 Days 29
If less than one day hr. _____ min. _____

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

10. Usual occupation Retired Police Officer

11. Industry or business _____

MOTHER FATHER { 12. Name Allsteadt

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. George Chas. Krouse

(b) Address Detroit, Mich.

17. (a) Removal (b) Date thereof 6-5-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Detroit, Mich

18. (a) Signature of funeral director Claude Prichard

(b) Address Excelsior Springs, Missouri

19. (a) June 6, 1947 (b) Caroline Dutsching
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Michigan (b) County Wayne 999

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

(d) Street No. 211 Cedarhurst Pl.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 4th
year 1947 hour 8 minute 45 P.M.

21. I hereby certify that I attended the deceased from MAY 22, 1947, to June 14, 1947
that I last saw him alive on June 4, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Cardiac Hypertension

Due to Arterio Sclerosis

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

Major findings: Of operations none

Of autopsy none §3A

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury 0

23. Signature W.C. Purviance M.D. (M. D. or other) _____

Address Excelsior Springs Mo Date signed 6-5-47

(Licensed Embalmer's Statement on Reverse Side) Ball Clinic

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 6-16-47

AUG 20 1947

AUG 13 1947

JUN 19 1947

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 Albert S. White

Licensed Embalmer No. 4168

P. O. Address Seclusias Springs, Me

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.