

FILED JUL 14 1947

State File No. _____

Registration District No. _____

Primary Registration District No. 6093

Registrar's No. 137

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall Mo R
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mo. State School 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Five weeks - 1939
(Specify whether years, months or days)

3. (a) PRINT FULL NAME

Albert Fred Krifer

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased 7-20-30
(Month) (Day) (Year)

8. AGE: Years 17 Months 4 Days 29 If less than one day hr. _____ min. _____

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

10. Usual occupation Invalid

11. Industry or business _____

12. Name Albert Fred Krifer

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

14. Maiden name Camillia Binger

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

16. (a) Informant Records Mo State School

(b) Address Marshall, Mo.

17. (a) Burial (b) Date thereat June 28-1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oran Cemetery

18. (a) Signature of funeral director T. S. Heisserich

(b) Address Oran, Mo.

19. (a) June 28-1947 (b) Hedney T. Gray
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline 97
(c) City or town Marshall Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June 25 day _____
year 1947 hour _____ minute 9 AM

21. I hereby certify that I attended the deceased from June 10 1947 to June 25-1947
that I last saw him alive on June 25-1947
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis - Inebriate

Due to _____

Due to _____

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

Major findings: Of operations 97 E

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) (e) Means of injury 0

23. Signature K. E. Gray M.D. (M. D. or other)

Address Marshall Mo. Date signed 6/25/47

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

17
0
0

0
0
0

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 7-11-47

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 _____

Licensed Embalmer No. 3235

P. O. Address Marshall, 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.