

No. 2
12-45
17-39
447070

State File No. **25157**

FILED AUG 7 1947

Registration District No. **378**

Primary Registration District No. **3058**

Registrar's No. **132**

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

1. PLACE OF DEATH:

(a) County **St Charles**
 (b) City or town **St Charles**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **St Joseph Hospital**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **Two weeks**
(Specify whether
 In this community **Life**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St Charles**
 (c) City or town **W of House Mo**
(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 _____

3. (a) PRINT FULL NAME

KRUGER, LENA

3. (b) If veteran, name war _____

3. (c) Social Security No. **None**

4. Sex **F** 5. Color or race **W**
 6. (a) Single, widowed, married, divorced **married**
 6. (b) Name of husband or wife **Merrill Kruger**
 6. (c) Age of husband or wife **48** years
 7. Birth date of deceased **Aug, 16, 1905**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
43 11 25 hr. min.

9. Birthplace **St Charles Co**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business _____

MOTHER FATHER

12. Name **Teason Vogt**
 13. Birthplace **St Charles, Co**
(City, town, or county) (State or foreign country)
 14. Maiden name **Kattie Mades**
 15. Birthplace **St Charles, Co**
(City, town, or county) (State or foreign country)

16. (a) Informant **Merrill Kruger**
 (b) Address **Defiance, Mo**

17. (a) **Burial** (b) Date thereof **7th, 28, -47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Defiance**

18. (a) Signature of funeral director **Marion Muehling**
 (b) Address **Wentzville Mo**

19. (a) **7-29-47** (b) **Jaime Hamilton**
(Date received local registrar) (Registrar's signature) #

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **23**
 year **1947** hour **8:45** minute **45 A M.**
 21. I hereby certify that I attended the deceased from **July 8** 19**47**, to **July 23** 19**47**
 that I last saw her alive on **July 22** 19**47**
 and that death occurred on the date and hour stated above.

Immediate cause of death
trauma cerebral hemorrhage - malignant hypertension
 Due to **hypertension, malignant hypertension**
 Due to _____

Duration **2 wks**

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

Major findings: _____
 Of operations _____

Of autopsy _____

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 _____

23. Signature **Lucretia S. Schumaker** (M. D. or other) **MD**
 Address **St Charles, Mo** Date signed **7/23/47**

RECEIVED
District Health Officer No. 9,
District File Number 8-5-47
Date Filed

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 *Marie Marchand*
Licensed Embalmer No. *24610*
P. O. Address *Wentzville*

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.

Registration District No. 310 Primary Registration District No. 3058

1. PLACE OF DEATH: St Charles
(a) County St Charles
(b) City or town St Charles
(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 _____ years, months or days

3. (a) PRINT FULL NAME Lena Krueger
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced on
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Aug 16 (Month) (Day) (Year)

8. AGE: Years 42 Months 1 Days 1 (If less than one day, hr. 110 min.)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) July 29-47 (b) Frankie Stewart
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1947 Hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____
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) (e) Means of injury _____

23. Signature _____ (M. D. or other)
Address _____ Date signed _____

SUPPLEMENTARY

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

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

525158