

No. 2
-2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12692

State File No. _____

FILED APR 24 1948

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1684

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Research Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 Days
(Specify whether
in this community 30 Yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 3208 East 73 rd
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Chester A. Krell

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex M

0

5. Color or race W

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

6. (b) Name of husband or wife Leota Krell

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

7. Birth date of deceased Dec. (Month)

20 (Day) 1895 (Year)

8. AGE: Years 52

Months 3

Days 25

If less than one day
hr. _____ min _____

9. Birthplace Penn.
(City, town, or county)

(State or foreign country)

10. Usual occupation Land Scaper

11. Industry or business _____

12. Name John Krell

13. Birthplace Penn.

(City, town, or county) Unknown

(State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown

(City, town, or county)

(State or foreign country)

16. (a) Informant L.W. Krell

(b) Address 3208 East 73 rd St.

17. (a) Burial

(Burial, cremation, or removal)

(b) Date thereof 4-17-48

(Month) (Day) (Year)

(c) Place: burial or cremation Florial Hills

18. (a) Signature of funeral director Stine & McClure

(b) Address Kansas City, Mo.

19. (a) 4-17-48

(Date received local registrar)

(b) Theraldine Holmes

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day Apr. 15
year 1948 hour _____ minute _____

21. I hereby certify that I attended the deceased from Feb. 27, 1948
19 _____ to Apr. 15, 19 48
that I last saw him alive on Apr. 15, 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary atherosclerosis
arteriosclerosis
Due to hypertension

Due to arteriosclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 92-a
Of autopsy yes

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 _____
23. Signature Dr. Blunt (M. D. or other) M.D.
Address 924 Prof. Bldg. Date signed 4/15/48

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..... *Robert W. Reed*
Licensed Embalmer No. *3745*
P. O. Address..... *H. C. 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.