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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 16 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20535
Registrar's No. 95

Registration District No. 310

Primary Registration District No. 3058

1. PLACE OF DEATH:
(a) County **St. Charles**
(b) City or town **St. Charles**
(c) Name of hospital or institution:
1155 Hall St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **50 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **St. Charles**
(c) City or town **St. Charles**
(If outside city or town limits, write "RURAL")
(d) Street No. **1155 Hall St**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Emma Kreder**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **5/** day **20/**
year **1948** hour **11** minute **45 P.M.**
21. I hereby certify that I attended the deceased from **9/20/47**
_____, 19____, to **5/20/48**, 19____
that I last saw h. **sc** alive on **5/60/48**, 19____
and that death occurred on the date and hour stated above.

4. Sex **F**
5. Color or race **W**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Charles Kreder**
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **October 21 1871**
(Month) (Day) (Year)

Immediate cause of death _____
arteriosclerosis heart. Disease. 3yrs
Due to **gen. arteriosclerosis** 3yrs
Due to _____

8. AGE: Years **76** Months **6** Days **29**
If less than one day _____ hr. _____ min.

Other conditions **Chr. Cholecystitis** 3yrs
(Include pregnancy within 3 months of death)

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

Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

10. Usual occupation **House keeper**
11. Industry or business **Home**
12. Name **Valentine Kreder**
13. Birthplace **Germany**
(City, town, or county) (State or foreign country)
14. Maiden name **Sophia Deitchmann**
15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Waldo Kreder**
(b) Address **1155 Hall St**
17. (a) **Burial** (b) Date thereof **May 23 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation **Weldon Springs Mo**
18. (a) Signature of funeral director **Thurman Paine**
(b) Address **St Charles Mo.**
19. (a) **June 3 1948** **Frank Hamilton**
(Date received local registrar) (Registrar's signature)

23. Signature **R. J. Bradley** (M. D. or other) **MD**
Address **126 S. Main St.** Date signed **5-20-48**

Date Filed JUN 15 1948

District File Number

District Health Officer No. 9

RECEIVED

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

Frederic V. Bane

, Registered Apprentice No. *510*

working under my personal supervision.

Signed

Frederic V. Bane

Licensed Embalmer No.

3157

P. O. Address

St. Charles 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.