

FILED JUL 26 1948

Registration District No. \_\_\_\_\_

Primary Registration District No. 4188

Registrar's No. 99

1. PLACE OF DEATH:

(a) County Gasconade  
(b) City or town Owensville  
(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 20 years  
years, months or days)

3. (a) PRINT FULL NAME Mary Elizabeth Krause

3. (b) If veteran, name war WW  
3. (c) Social Security No. 44

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Fred Krause, Sr.  
6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased December 24 1878  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	69	6	15	hr. min.

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

10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

MOTHER FATHER {  
12. Name Eugene Jarvis 9  
13. Birthplace Not known 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Florence Givens  
15. Birthplace Marion County Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Ben Krause  
(b) Address Owensville, Missouri

17. (a) Burial (b) Date thereof 7-11-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Owensville City Cem.

18. (a) Signature of funeral director Melford N. N. Write  
(b) Address Owensville, Mo.

19. (a) 7-15-48 (b) Dorothy Hackman  
(Date received local registrar) (Registrar's signature) 263

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Gasconade 37  
(c) City or town Owensville  
(If outside city or town limits, write "RURAL") 2  
(d) Street No. \_\_\_\_\_ (If rural, give location) 0  
(e) Citizen of foreign country? No (Yes or No) 0  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9  
year 1948 hour 5 minute 30 p. M.

21. I hereby certify that I attended the deceased from July 7 1948 to July 9 1948  
and that I last saw her alive on July 9 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension.

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 830  
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) (c) Means of injury L

23. Signature S. H. Bradley (M. D. or other) DD.  
Address Owensville, Mo. Date signed 7-10-48

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

223

RECEIVED  
District Health Officer No. 9,  
District File Number  
JUL 23 1948  
Date Filed

AUG 4 1948

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.....  
**Harvey Kahle**....., Registered Apprentice No..... **9**  
.....  
working under my personal supervision.

Signed..... *Melford A. H. Winters*.....  
Licensed Embalmer No..... **3838**.....  
P. O. Address..... **Owensville, 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.

Registration District No. 118

Primary Registration District No. 4188

1. PLACE OF DEATH:  
(a) County Gasconade  
(b) City or town Quenemo  
(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) (Specify whether

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.....

3. (a) PRINT FULL NAME Mary E Krause  
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 m

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

7. Birth date of deceased. Dec 24  
(Month) (Day) (Year)

8. AGE: Years 69 Months 6 Days 6 If less than one day hr. min.

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

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)  
(c) Place: burial or cremation.....

18. (a) Signature of funeral director..... (b) Address.....

19. (a) July 15, 1948 (b) Dorothy Hoekman  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug Year 1948 (hour) 11 minute 15 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

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

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

B  
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8880

S-22774