

FILED JAN 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 823
Registrar's No. 53

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY OR TOWN <u>Springfield,</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield,</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1220 W. Madison</u>		d. STREET ADDRESS (If rural, give location) <u>1220 W. Madison</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Gustav</u> b. (Middle) <u>R.</u> c. (Last) <u>Krueger</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>January 18, 1950</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 1, 1877</u>	9. AGE (In years last birthday) <u>72</u> IF UNDER 1 YEAR Months <u>7</u> IF UNDER 12 HRS. Days <u>17</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner-Florist</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Billings, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Williamck Krueger</u>	13b. MOTHER'S MAIDEN NAME <u>Frederika Achterberg</u>	14. NAME OF HUSBAND OR WIFE <u>Mrs. Agnes Krueger</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Agnes Krueger Springfield, Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>		<u>48 hrs.</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>		<u>Undeterm.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none.</u>		<u>6 mos.</u>	

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR _____
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22. I hereby certify that I attended the deceased from Dec 24, 1949 to Jan 18, 1950, that I last saw the deceased alive on Jan 17, 1950, and that death occurred at 5:50 p.m. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Don J. Silsby M.D.</u>	23b. ADDRESS <u>Springfield, Mo.</u>	23c. DATE SIGNED <u>1-19-50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan. 22, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Peters</u>	24d. LOCATION (City, town, or county) (State) <u>Billings, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>1-20-50</u>	REGISTRAR'S SIGNATURE <u>W.F. Handley M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Norman Schupf Home Springfield, Mo.</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

2396
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Leah Forman

Signed _____

Student Embalmer

Licensed Embalmer No. _____

3177

P. O. Address _____

Springfield 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.