

FILED APR 7 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 8035

8035

BIRTH NO. _____ REG. DIST. NO. 71 PRIMARY REG. DIST. NO. 3012 Registrar's No. 31

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>Brown</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u> <u>8120</u>	
c. LENGTH OF STAY (in this place) <u>6</u> Weeks		d. STREET ADDRESS (If rural, give location) <u>Near Mt Sterling</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Mitchell Clinic</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u> b. (Middle) <u>CHRISTINE</u> c. (Last) <u>KROFT</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 10 1950</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 6 1877</u>
9. AGE (In years last birthday) <u>73</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 10 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Galine Ill</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>not known</u>		13b. MOTHER'S MAIDEN NAME <u>not known</u>	14. NAME OF HUSBAND OR WIFE <u>Mr Earl Kroft</u>
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>Earl Kroft-Mt Sterling Illinois</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Myocarditis</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>	
INTERVAL BETWEEN ONSET AND DEATH _____		<u>431X</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
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) _____	
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? _____	
22. I hereby certify that I attended the deceased from <u>Jan 20 1950</u> to <u>Mar 10 1950</u> , that I last saw the deceased alive on <u>Mar 10 1950</u> , and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>K. F. Laughlin, D.O.</u>		23b. ADDRESS <u>Excelsior Springs Mo</u>	23c. DATE SIGNED <u>3/11/50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>	24b. DATE <u>3/11/1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Chillicothe Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Chillicothe Ill</u>
DATE REC'D BY LOCAL REG. <u>2/11/50</u>	REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Hope Fund Home</u> ADDRESS: <u>Excelsior Springs Mo</u>	

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

0247

RECEIVED

MAR 27

District Health Officer No. 8,

District File Number _____

Date Filed 4/6/50

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 James A. Moles

Signed _____
Student Embalmer

Licensed Embalmer No. 3296

P. O. Address Ex. Springs 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.