

FILED APR 25 1950

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15411

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 6076		Registrar's No. 929	
1. PLACE OF DEATH a. COUNTY ST. LOUIS				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS MO		c. LENGTH OF STAY (In this place) NO		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		3019	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION LEMAY NURSING HOME				d. STREET ADDRESS (If rural, give location) 819 WILMINGTON			
3. NAME OF DECEASED (Type or Print)		a. (First) ANDREW		b. (Middle) W.		c. (Last) KREN	
4. DATE OF DEATH		(Month) APRIL		(Day) 8		(Year) 1950	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH Nov. 25 1864	
9. AGE (In years last birthday) 85		IF UNDER 1 YEAR Months 4 Days 13		IF UNDER 1 HR. Hours _____ Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED DAY LABORER				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) BOHEMIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME PROKOP KERN		13b. MOTHER'S MAIDEN NAME BARBARA HRDLICKA		14. NAME OF HUSBAND OR WIFE _____	
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 ANDREW KERN KREN ADDRESS _____			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
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. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral Hemorrhage				About 1 mo	
		ANTECEDENT CAUSES					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b) Arteriosclerosis - Senility					
		DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION 331X				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____ m.		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 July 1948 , to March 18, 1950 , and that death occurred at 9:30 p.m. , from the causes and on the date stated above.							
23a: SIGNATURE Arnold Klein MD (Degree or title)				23b. ADDRESS 2637 S. Kingshighway		23c. DATE SIGNED 7/10/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE APRIL 11 1950		24c. NAME OF CEMETERY OR CREMATORY S.S. PETER + PAUL		24d. LOCATION (City, town, or county) (State) ST. LOUIS MO	
DATE REC'D BY LOCAL REG. 4-10-50		REGISTRAR'S SIGNATURE Herbert A. Dombke		25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kuti ADDRESS 2906 Leovain			

(Licensed Embalmer's Statement on Reverse Side)

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

712

11 30 AM to 4 00 PM

Handwritten signature/initials

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Leo J. Pusde

Signed.....
Student Embalmer

Licensed Embalmer No. *3989*

P. O. Address *St. Louis, 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.