

FILED JAN 26 1951

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **43899**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **217** PRIMARY REG. DIST. NO. **6076** Registrar's No. **3175**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Baden, Mo.</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Halls Ferry Memorial Home</b>		d. STREET ADDRESS (If rural, give location) <b>4471 Lee Ave.</b>	

3. NAME OF DECEASED (Type or Print) <b>Thekla M. Kruenegel</b>		4. DATE OF DEATH <b>Dec. 29th, 1950</b>	
a. (First)		b. (Middle)	
c. (Last)		5. DATE OF BIRTH <b>12/5/1883</b>	
6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	9. AGE (In years last birthday) <b>67</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? _____

13a. FATHER'S NAME <b>A. R. Hennig</b>	13b. MOTHER'S MAIDEN NAME <b>Wilhelmina Beyer</b>	14. NAME OF HUSBAND OR WIFE <b>Ernst F. Kruenegel</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Ernst Kruenegel</b> ADDRESS <b>4471 Lee Ave.</b>

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral thrombosis, multiple</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis, cerebral</b>		<b>1 year</b>
	DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS (1) <b>Parkinson's syndrome</b> Conditions contributing to the death but not related to the disease or condition causing death. (2) <b>Multiple sclerosis</b> (3) <b>Dementia</b>		<b>1) 6 months</b> <b>2) 1 month</b> <b>3) unknown</b>

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <b>332X</b>	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) _____	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 **Dec 5, 1950**, to **Dec 29, 1950**, that I last saw the deceased alive on **Dec 26, 1950**, and that death occurred at **1:30P m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Lewis Littmann MD</b> (Degree or title)	23b. ADDRESS <b>8231 Clayton Rd (17)</b>	23c. DATE SIGNED <b>12/30/50</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Jan 2nd 1951</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Bethany</b>
24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>		

DATE REC'D BY LOCAL REG. <b>12/30/50</b>	REGISTRAR'S SIGNATURE <b>Herbert R. ...</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Kraeger-Voss, Inc.</b> ADDRESS <b>3402 N. Kingshigh</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

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JUN 3 1954

JUN 3 1954

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 Me

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed Gay W. Wilkinson

Licensed Embalmer No. 3575

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.