

FILED DEC 1 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39290

BIRTH NO. _____		REG. DIST. NO. 218		PRIMARY REG. DIST. NO. 1003		Registrar's No. 10325	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 40 yrs.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2069	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5867 Wabada Ave.				d. STREET ADDRESS (If rural, give location) 5867 Wabada Ave.			
3. NAME OF DECEASED (Type or Print) Elizabeth E. Kreutzer			a. (First) Elizabeth b. (Middle) E. c. (Last) Kreutzer			4. DATE OF DEATH (Month) (Day) (Year) Nov. 18 1951	
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2		8. DATE OF BIRTH July 15 1864	
9. AGE (In years last birthday) 87		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME Michael Murphy		13b. MOTHER'S MAIDEN NAME Margaret Haley		14. NAME OF HUSBAND OR WIFE Henry F. Kreutzer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mary Kreutzer, 5867 Wabada Ave.			
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.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Senility extreme senile dementia</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Generalized arterio-sclerosis</i> DUE TO (c) <i>Cardiac + Renal decompensation - Generalized edema</i> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Heavy Falls for the last 3 yrs</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs +</i> <i>2 years</i> <i>3 +</i>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <i>Last fall Nov 9 - Fract of neck of left femur + followed by Shocks</i>		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.) <i>at home</i>		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) <i>D.K. Missouri</i> (STATE) <i>Mo.</i>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>second in last 8 yrs last Nov 9/51</i>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Fell in bed room</i> <i>fell</i> <i>Sept 21/26/51</i> <i>9/30</i>			
22. I hereby certify that I attended the deceased from <i>March 9/ 1928</i> , to <i>Nov 18/ 1951</i> , that I last saw the deceased alive on _____, 19____, and that death occurred at <i>7:45p</i> m., from the causes and on the date stated above.							
23a. SIGNATURE <i>Richard A. Smith M.D.</i> (Degree or title) _____				23b. ADDRESS <i>3734 Jennings Rd</i>		23c. DATE SIGNED <i>11/20/51</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>11/21/51</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Calvary Cemetery</i>		24d. LOCATION (City, town, or county) (State) <i>St. Louis Mo.</i>	
DATE REC'D BY LOCAL REG. <i>NOV 20 1951</i>		REGISTRAR'S SIGNATURE <i>Richard A. Smith M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Drehmann-Harral, 1905 Union Blvd.</i>			

Dr. L. B. Tlerron,
3734 Jennings Rd.

(1:30 to 7)

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.

Student
Student Embalmer

Signed.....



Licensed Embalmer No. 4237

P. O. Address St. Louis

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.