

FILED AUG 4 1952

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 24183

715

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. _____

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

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY POLK	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BOLIVAR, Rural 1840	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOHNS		d. STREET ADDRESS (If rural, give location) 12 Mi. S E OF BOLIVAR	
3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) — c. (Last) KROUTIL		4. DATE OF DEATH (Month) (Day) (Year) JULY 28, 1952	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH JUNE 13, 1909
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	9. AGE (In years last birthday) 44
11. BIRTHPLACE (City and State or Foreign Country) POLK CO. MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME ANTON KROUTIL		13b. MOTHER'S MAIDEN NAME MARY VODICHA	14. NAME OF HUSBAND OR WIFE XXX
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES W.W.II		16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME HELEN KROUTIL BOLIVAR, MO. ADDRESS
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage, Basal Ganglia, Right Cerebral arteriosclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Portal Cirrhosis, Early INTERVAL BETWEEN ONSET AND DEATH 30 hours	
19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION none		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) none	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 July 28, 1952, to July 28, 1952, that I last saw the deceased alive on July 28, 1952, and that death occurred at 2:55 P. M., from the causes and on the date stated above.			
23a. SIGNATURE William J. Day (Degree or title) M.D.		23b. ADDRESS 609 Cherry, Springfield, Mo.	23c. DATE SIGNED 7/28/52
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 7/31/52	24c. NAME OF CEMETERY OR CREMATORY KARLIN CEMETARY	24d. LOCATION (City, town, or county) (State) S. of BOLIVAR, MO.
DATE REC'D BY LOCAL REG. 7-29-52	REGISTRAR'S SIGNATURE Edith Williamson Registrar	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H.H. LOHMEYER SPRINGFIELD, MO.	

SEP 1952

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 *James T. Swadley*.....

Licensed Embalmer No. *4815*.....

P. O. Address *Springhill*.....

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.