

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3371**
0918
Registrar's No.

No. 300
10-48

FILED FEB 11 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

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 town) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2169	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 16 3638 Arkansas Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) JOSEPHINE		b. (Middle) KROLL	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Jan. 24 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 8, 1875
9. AGE (In years last birthday) 77		10. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (City and State or Foreign Country) Germany 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Unknown Mueller		13b. MOTHER'S MAIDEN NAME Unknown	
13c. NAME OF HUSBAND OR WIFE Paul Kroll			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Paul Kroll		ADDRESS 3638 Arkansas 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Metastatic Carcinoma</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of the Bladder</u> DUE TO (c) 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION July 15, 1952		19b. MAJOR FINDINGS OF OPERATION Resectable Carcinoma of the Bladder	
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) 181X	
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 10, 1952 to Jan 24, 1953, that I last saw the deceased alive on Jan 24, 1953, and that death occurred at 11:15 A.M., from the causes and on the date stated above.			
23a. SIGNATURE Robert T. Huey, M.D.		23b. ADDRESS 634 No Grandview	
23c. DATE SIGNED 1/26/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Jan. 27, 1953	24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park	24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
DATE REC'D BY LOCAL REG. JAN 27 1953	REGISTRAR'S SIGNATURE C. Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser 4228 S. Kingshighway Bl	

(Licensed Embalmer's Statement on Reverse Side)

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 Edwin M. Herwath

Licensed Embalmer No. 3024

P. O. Address _____

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.