

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7714

State File No.

Registrar's No. **1445**

No. 300

10.48

FILED FEB 26 1953

318

1003

BIRTH NO.

REG. DIST. NO.

PRIMARY REG. DIST. NO.

1. PLACE OF DEATH a. COUNTY		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) ST. LOUIS MO		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS 2169	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3944 KEOKUK 16		d. STREET ADDRESS (If rural, give location) 3944 KEOKUK			
3. NAME OF DECEASED (Type or Print) FRANCIS - KRENNING		a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) FEB. 6 1953
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH DEC. 1 1878	9. AGE (In years last birthday) 74 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN		10b. KIND OF BUSINESS OR INDUSTRY CONTINENTAL CAN		11. BIRTHPLACE (State or foreign country) MISSOURI	12. CITIZEN OF WHAT COUNTRY? U
13a. FATHER'S NAME FRANK KRENNING		13b. MOTHER'S MAIDEN NAME MARY FREY		14. NAME OF HUSBAND OR WIFE ROSE KRENNING	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 488-10-1083		17. INFORMANT'S SIGNATURE OR NAME ADDRESS ROSE KRENNING 3944 KEOKUK	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
<p>* This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis			?
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchiectasis.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input 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? 4222	
22. I hereby certify that I attended the deceased from Dec. 21 1952 , to Feb 6, 1953 , that I last saw the deceased alive on Feb 6, 1953 , and that death occurred at 11 A. m. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Dr. Wayne M. Weaver M.D.		23b. ADDRESS 5437A Southwood Ave.		23c. DATE SIGNED 2/6/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE FEB. 9 1953		24c. NAME OF CEMETERY OR CREMATORY NEW ST. MARCUS	
				24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO.	
DATE REC'D BY LOCAL REG. FEB 6 1953		REGISTRAR'S SIGNATURE J. C. Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. Thomas Latis 2906 Georgia	

(Licensed Embalmer's Statement on Reverse Side)

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

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 Leo J. Buddle

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.