

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 26600
6238

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____				
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois				b. COUNTY Madison		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (in this place) 1 mo		c. CITY OR TOWN Granite City		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin DesLoge Hospital				e. STREET ADDRESS (If rural, give location) 2307 Benton Avenue., 8120 S						
3. NAME OF DECEASED (Type or Print)			a. (First) Laura		b. (Middle) Margaret		c. (Last) Krill			
							4. DATE OF DEATH June 20 1953			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH May 3 1878		9. AGE (in years last birthday) 75		
								IF UNDER 1 YEAR Days		
								IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At Home			11. BIRTHPLACE (City and State or Foreign Country) Missouri			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Andrew Eiler			13b. MOTHER'S MAIDEN NAME Marv Hoffman			14. NAME OF HUSBAND OR WIFE Joseph H. Krill				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. Nil		17. INFORMANT'S SIGNATURE OR NAME None		ADDRESS Eulalia Francis, Granite City Ill.			
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH		
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Cervix								
		ANTECEDENT CAUSES								
		*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.								
		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.								
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) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 171X						
22. I hereby certify that I attended the deceased from 12-1-1952, to 6-19-1953, that I last saw the deceased alive on 6-18-1953, and that death occurred at 2:13 a.m., from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title) _____				23b. ADDRESS 1750 4500 Alvin St. St. Louis Mo				23c. DATE SIGNED 6-20-53		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 6-22-53		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) Edwardsville, Illinois				
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUN 22 1953		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Albert H. Hoppe, 4700 Washington				

(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.....
Signature of Student Embalmer

Signed *John S. Dennis*.....
Licensed Embalmer No. *419*.....
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.