

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4925**
504

BIRTH NO. **FILED FEB 18 1954** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
c. LENGTH OF STAY (In this place) 33		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 SAINT LUKES		e. STREET ADDRESS (If rural, give location) 302-E-43rd ST	

3. NAME OF DECEASED (Type or Print) a. (First) HERBERT b. (Middle) HARLOW c. (Last) KROUT			4. DATE OF DEATH (Month) (Day) (Year) 1 30 54		
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 12-8-1903	9. AGE (In years last birthday) 50	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Days	IF UNDER 15 MIN. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASST. CUSTODIAN		10b. KIND OF BUSINESS OR INDUSTRY SCHOOL BOARD		11. BIRTHPLACE (City and State or Foreign Country) BIRCH TREE MO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME ARREN JASPER KROUT		13b. MOTHER'S MAIDEN NAME LULA BELL JOHNSON		14. NAME OF HUSBAND OR WIFE None	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes W.W.I.		16. SOCIAL SECURITY NO. 496-24-6659		17. INFORMANT'S SIGNATURE OR NAME Ray E. Krout		ADDRESS 6024-E-16th ST	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Rupture of aortic aneurysm of brain		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rupture of aortic aneurysm of brain		INTERVAL BETWEEN ONSET AND DEATH 10 days	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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. none		330X	

19a. DATE OF OPERATION —		19b. MAJOR FINDINGS OF OPERATION none		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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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)	
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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?	
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22. I hereby certify that I attended the deceased from **1-19**, 19**54**, to **1-30**, 19**54**, that I last saw the deceased alive on **1-30**, 19**54**, and that death occurred at **10 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE F. H. Hodgson (Degree or title) M.D.		23b. ADDRESS 4301 Main		23c. DATE SIGNED 2-1-54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2-2-54		24c. NAME OF CEMETERY OR CREMATORY MT WASHINGTON		24d. LOCATION (City, town, or county) (State) KANSAS CITY MO	
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DATE REC'D BY LOCAL REG. 2-1-54		REGISTRAR'S SIGNATURE Geraldine Smith		25. FUNERAL DIRECTOR'S SIGNATURE John P. Sheil		ADDRESS Kansas City Mo	
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(Licensed Embalmer's Statement on Reverse Side)

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

MAR 17 1957

4301-
Apr 130
V43323

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 *Richard E. Carroll*

Licensed Embalmer No. 482

P. O. Address *K. P. ...*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (E 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.