

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30673

State File No. \_\_\_\_\_

FILED SEP 24 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4127

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
c. LENGTH OF STAY (in this place) <u>50 YRS.</u>		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 <u>ST. LUKE'S HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>75 5045 THE PASSE</u> <u>275 0</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>LENA</u>	b. (Middle) <u>LYNN A.</u>	c. (Last) <u>KRUG</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>AUGUST 26 1954</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>June 2 1885</u>	9. AGE (In years last birthday) <u>69</u>	if UNDER 1 YEAR Months _____ Days _____	if UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>5 SWITZERLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>ALBERT ANDERMOTT</u>	13b. MOTHER'S MAIDEN NAME <u>AGATHA Risi</u>	14. NAME OF HUSBAND OR WIFE <u>ALFRED KRUG</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MRS. JOSEPHINE DABNER</u> ADDRESS <u>5045 THE PASSE KANSAS CITY, MO.</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		19. DATE OF OPERATION  19b. MAJOR FINDINGS OF OPERATION
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Arteriosclerosis.</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 8/15, 1954 to 8/26, 1954, that I last saw the deceased alive on 8/26, 1954, and that death occurred at 11:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>William B. Allen MD</u> (Degree or Title)	23b. ADDRESS <u>Kansas City Mo 8/27/54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>August 28, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY CEMETERY</u>	24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY, MISSOURI</u>
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DATE REC'D BY LOCAL REG. <u>8-28-54</u>	REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>D.W. NEWCOMBS</u> ADDRESS <u>SOUS 1331 BRUSH CREEK</u>
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KANSAS CITY, MO.

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD William B. Allen MD

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 *Chester K. Brown* .....

Licensed Embalmer No. *49* .....

P. O. Address *KC Mo* .....

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