

STANDARD CERTIFICATE OF DEATH State File No. **31956**

FILED OCT 4 1954 REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8142**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Jennings 4 198	
d. FULL NAME OF HOSPITAL OR INSTITUTION En-route City Hosp.		d. STREET ADDRESS (If rural, give location) 8334 Shady Lane	
3. NAME OF DECEASED (Type or Print) a. (First) JOSEPH b. (Middle) KRAL c. (Last) KRAL		4. DATE OF DEATH (Month) (Day) (Year) 9-1-1954	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 8-5-193
9. AGE (In years last birthday) 61		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick-layer		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) St. Paul Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.			
13a. FATHER'S NAME Albert KRAL		13b. MOTHER'S MAIDEN NAME Mary Koncelik	14. NAME OF HUSBAND OR WIFE -----
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW #1		16. SOCIAL SECURITY NO. WW #1	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Anna Abeli-6436 McCune 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary congestion ANTECEDENT CAUSES 2. Cardiac hypertrophy Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 2. Cardiac hypertrophy 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 checked="" 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4343
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1:36 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE James J. Taylor (Degree or title) 3		23b. ADDRESS 3rd Clark	23c. DATE SIGNED 9-5-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9-7-1954	24c. NAME OF CEMETERY OR CREMATORY National Cem.	24d. LOCATION (City, town, or county) (State) Jefferson Brks., Mo.
DATE REC'D BY LOCAL REG. SEP 3 1954		REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Moydell Funeral Home, 1926 Allen Ave

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY--USING UNFAADING BLACK INK--MAKE A PERMANENT RECORD

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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 Reinhold K. Lehmann

Licensed Embalmer No. 3395

P. O. Address St. Louis 7, 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.