

FILED APR 27 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13437  
State File No. ....  
2339  
Registrar's No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>2 Days</b>	c. CITY OR TOWN <b>Northwoods Mo.</b> <sup>4150</sup>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Faith Hospital</b>		STREET ADDRESS (If rural, give location) <b>3835 Oakridge Ave.</b>	

3. NAME OF DECEASED (Type or Print) <b>Oscar</b>	a. (First)	b. (Middle) <b>J.</b>	c. (Last) <b>Hentrich</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>March 13, 1955</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>July 3, 1874</b>	9. AGE (In years last birthday) <b>80</b>	IF UNDER 1 YEAR Months <b>8</b> Days <b>16</b>	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Cost Accountant</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>William Krull</b>	13b. MOTHER'S MAIDEN NAME <b>Sophia Albrecht</b>	14. NAME OF HUSBAND OR WIFE <b>Marie</b>
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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)	16. SOCIAL SECURITY NO. <b>492-09-5640a</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Jack Hentrich</b>	ADDRESS <b>3835 Oakridge Ave.</b>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Subarachnoid hemorrhage</b>		
ANTECEDENT CAUSES		DUE TO (b) <b>arteriosclerotic Cardiovascular disease</b>	
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		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 checked="" 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 checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>4221</b>
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22. I hereby certify that I attended the deceased from **12/8, 1951** to **3/13, 1955**, that I last saw the deceased alive on **3/12, 1955** and that death occurred at **1:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Robert A. Bauer</b>	(Degree or Title) <b>MA</b>	23b. ADDRESS <b>373 Goodfellow</b>	23c. DATE SIGNED <b>3/14/55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>3/15/55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Morrilton, Arkansas</b>
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DATE REC'D BY LOCAL REG. <b>MAR 14 1955</b>	REGISTRAR'S SIGNATURE <b>Carl Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Gebken</b>	ADDRESS <b>Sons 2630 Gravois Ave.</b>
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WRITE PLAINLY—USING UNFADING 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.....  
Signature of Student Embalmer

Signed *Dill C. Branson*.....

Licensed Embalmer No. *470*.....

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.