

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38493

FILED DEC 12 1955

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

State File No. 10327
Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL, and give town) <u>ST. LOUIS Mo</u>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>ST. LOUIS</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>D.O.A. CITY HOSPITAL</u>		e. STREET ADDRESS (If rural, give location) <u>3500 NEBRASKA</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>HENRY</u> b. (Middle) <u>J.</u> c. (Last) <u>KROLL</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 25 1955</u>		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	
8. DATE OF BIRTH <u>MAY 10 1887</u>		9. AGE (In years last birthday) <u>68</u>		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUSCH SELZER</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>WISCONSIN</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>JACOB KROLL</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>MAE KROLL</u>	
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. <u>489-05-1074</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MAE KROLL 3500 NEBRASKA</u>	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)					
MEDICAL CERTIFICATION					
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute coronary Infarct (massive)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
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.					
MORIBUND CONDITIONS, if any, giving rise to the above cause (a) stating the underlying cause last.					
DUE TO (b) <u>Chronic myocarditis</u>				} <u>3 yrs</u>	
DUE TO (c) <u>Chronic Hypertension</u>					
DUE TO (c) <u>Early senile changes</u>					
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 <u>420.1</u>			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?	
22. I hereby certify that I attended the deceased from <u>2-6, 1954</u> , to <u>11-19, 1955</u> , that I last saw the deceased alive on <u>11-19, 1955</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>Walter H. Berger MD</u>		23b. ADDRESS <u>3108 S. Grand St. Louis 18 Mo</u>		23c. DATE SIGNED <u>11-26-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>Nov. 28 1955</u>		24c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM.</u>	
24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas Kutes 2906 Lewis</u>			
DATE REC'D BY LOCAL REG. <u>NOV 28 1955</u>		REGISTRAR'S SIGNATURE <u>Carl Smith Mo</u>			

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 *Samuel C. Hill*.....

Licensed Embalmer No. *434*.....

P. O. Address *2906 S. ...*.....

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.