

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29552

FILED AUG 24 1956

STATE FILE NUMBER

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. 126

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Scott		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Mississippi	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sikeston, Mo Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Charleston, Mo. Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Delta Hospital Length of stay in 1b		d. STREET (If outside, give location) ADDRESS E. Commercial St. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Walter S. Krebs			4. DATE OF DEATH Month Day Year August 8, 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 31, 1883
9. AGE (In years last birthday) 72		10. KIND OF BUSINESS OR INDUSTRY Self	11. BIRTHPLACE (City and state or country) Pemiscott County Mo
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Krebs		14. MOTHER'S MAIDEN NAME Martha Krebs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no. or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 332X	
17. INFORMANT Carl Krebs New Madrid, Missouri Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis, Left Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hemiplegia, Cong. L. R. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 30 days 30 days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from July 10 1956 to Aug 8 1956 and last saw her alive on Aug 8 1956 Death occurred at 8:45 AM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Andy Blount M.D.		22b. ADDRESS Sikeston Missouri	
		22c. DATE SIGNED 8-13-56	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/10/1956	
23c. NAME OF CEMETERY OR CREMATORY Mounds Cemetery		23d. LOCATION (City, town, or county) (State) New Madrid, Mo.	
24. FUNERAL DIRECTOR ADDRESS Mc Mickle Funeral Home Charleston Missouri		25. DATE RECD. BY LOCAL REG. 8-14-56	
		26. REGISTRAR'S SIGNATURE Miss. E. Hunter	

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(Licensed Embalmer's Statement on Reverse Side)

DATE RECEIVED AUG 20 1956

SCOTT CO. HEALTH DEPT.

CO. FILE No. 856-175

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.....
Licensed Embalmer No. 469

P. O. Address Charleston

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.