

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED FEB 4 1957

318

1003

State File No. 2892

585

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give town or township) St. Louis		c. LENGTH OF STAY (in this place) 27 years		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 16 Missouri Baptist Hospital 2125 1615 Lindell Boulevard				e. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) FRED		a. (First)		b. (Middle) R.		c. (Last) KROEGER	
4. DATE OF DEATH January 17 1957		5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Nov. 22, 1885		9. AGE (In years last birthday) 71		10. IF UNDER 1 YEAR Months 1 Days 25		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Investments		10b. KIND OF BUSINESS OR INDUSTRY Oil Investments		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Henry W. Boekenkroeger		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Grayce T. Kroeger			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Walter C. Boekenkroeger, E. St. Louis, Ill			
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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral thromboses</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive arteriosclerosis, cerebral thromboses</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>H2O-Q</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? <input type="checkbox"/> 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>January, 1955</u> , to <u>January 17, 1957</u> , that I last saw the deceased alive on <u>January 17, 1957</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Earl Smith M.D.</u>				23b. ADDRESS <u>812 Olive St. St. L.</u>		23c. DATE SIGNED <u>1-19-57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-21-57		24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		24d. LOCATION (City, town, or county) (State) Belleville Illinois	
DATE REC'D BY LOCAL HEALTH DEPT. JAN 19 1957		REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. H. H.</u>		ADDRESS E. St. Louis, Ill	

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 *W. K. Harris*.....

Licensed Embalmer No. *316*.....

P. O. Address *E. 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.