

THE DIVISION OF HEALTH OF MISSOURI 27804-58
STANDARD CERTIFICATE OF DEATH

58-019876
State File No.

5369
Registrar's No.

FILED MAY 29 1958

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY Missouri		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) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Booth Memorial Hospital		d. STREET ADDRESS (If rural, give location) 3740 Marine Avenue	
3. NAME OF DECEASED a. (First) Magdalene b. (Middle) Fern c. (Last) Krause		4. DATE OF DEATH (Month) (Day) (Year) May 13 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____	8. DATE OF BIRTH April 27, 1958
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 15 IF UNDER 1 YEAR: Hours _____ Min. _____
11. BIRTHPLACE (State or foreign country) St. Louis Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME XXXXXX	13b. MOTHER'S MAIDEN NAME Catherine Dorothea Krause	14. NAME OF HUSBAND OR WIFE none
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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 E. Thomas Berman	ADDRESS 3033 N. Euclid Ave
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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, asphyxia, etc. *It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH W.B.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hydrocephalus		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 752+		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Prematurity			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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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) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from **27 Apr, 1958**, to **13 May, 1958**; that I last saw the deceased alive on **12 May, 1958**, and that death occurred at **2:45** m., from the causes and on the date stated above.

23a. SIGNATURE E. Thomas Berman	(Degree or title) M.D.	23b. ADDRESS 3740 Marine St. Louis, Mo.	23c. DATE SIGNED 13 May 58
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24a. BURIAL, CREMATION, REMOVAL (Specify) _____	24b. DATE 5-31-58	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. MAY 22 '58	REGISTRAR'S SIGNATURE Paul Smith	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Svc.	ADDRESS 4104-06 Manchester
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BIRTH# 9559
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

BOOTH MEM
4-14

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.