Health,
& Welfare
Public
Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-030654
STATE FILE NUMBER

FILED SEP 11 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8479

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY /
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN Imperial — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 08 Deaconess Hospital — Length of stay in 1b 229	d. STREET ADDRESS (If outside, give location) Rt. 3 Box 390 — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First MINNIE	Middle A.	Last KREUTER	4. DATE OF DEATH Month Sep. Day 1 Year 1958
5. SEX Female	6. COLOR OR RACE / White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ / DIVORCED ☐	8. DATE OF BIRTH Nov.11,1888	9. AGE (In years last birthday) 69 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St. Louis, Mo. 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Emil Oventrop	13b. MOTHER'S MAIDEN NAME Louise Giese	14. NAME OF HUSBAND OR WIFE William H. Kreuter		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) None	16. SOCIAL SECURITY NO. 489-12-7074	17. INFORMANT William H. Kreuter Address Rt.#3 Box 390		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of Rt Colon — INTERVAL BETWEEN ONSET AND DEATH 1 YEAR

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)

DUE TO (c) 153.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐ /

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 8/4/58, to 9/1/58 and last saw her/him alive on 9/1/58

Death occurred at 7:10 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Simon X Houston M.D.

22b. ADDRESS 7820 Carondohet

22c. DATE SIGNED 9/2/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Sep.4,1958	23c. NAME OF CEMETERY OR CREMATORY Friedens Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR Kriegshauser	ADDRESS 4228 S.Kingshighway	25. DATE RECD. BY LOCAL REG. SEP 2 58	26. REGISTRAR'S SIGNATURE J Earl Smith, M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

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 William D. White

Licensed Embalmer No. 4291

P. O. Address [illegible]

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.