

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045941

STATE FILE NUMBER

FILED JAN 12 1959

Registration District No.

318

Primary Registration District No.

1008

Registrar's 12754

300
1-57

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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS, MO.</i>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>ST. LOUIS</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>25 ST. LOUIS CITY HOSP. #1</i>			Length of stay in lb <i>#1</i>	d. STREET ADDRESS (If outside, give location) <i>259 707 N 6TH ST.</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>EDWARD (AKA EDWARD LOWELL)</i> Middle <i>EDWARD</i> Last <i>KROEKER</i>				4. DATE OF DEATH Month <i>DEC.</i> Day <i>31</i> Year <i>1958</i>					
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>MAY 6, 1874</i>		9. AGE (In years last birthday) <i>84</i>	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) <i>AT HOME</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>St. Louis, Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13a. FATHER'S NAME <i>THOMAS KROEKER</i>			13b. MOTHER'S MAIDEN NAME <i>-----PABST</i>			14. NAME OF HUSBAND OR WIFE <i>BERTHA</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO. <i>572-03-6460A</i>		17. INFORMANT <i>MRS W J KOEHLER #4 HILLAND RD.</i>			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) <i>myocardial infarction</i>							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <i>coronary atherosclerosis</i>	DUE TO (c) <i>420.1</i>							
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 <input checked="" type="checkbox"/> NO <input 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 <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 <i>12/30/58 11:A.M.</i> to <i>12/31/58</i> and last saw her alive on <i>12/31/58</i> Death occurred at <i>3:25 P.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>John M. Burns, M.D.</i> (Degree or title)				22b. ADDRESS <i>1515 LAFAYETTE AVE</i>		22c. DATE SIGNED <i>1/1/59</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>		23b. DATE <i>1/2/1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>SUNSET BURIAL PARK</i>		23d. LOCATION (City, town, or county) (State) <i>AFFTON, Mo.</i>				
24. FUNERAL DIRECTOR <i>J L ZIEGENHEIN & SONS 7027 GRAVOIS</i>			ADDRESS		25. DATE RECD. BY LOCAL REG. <i>JAN 2 '59</i>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith MD</i>		

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 *Donald E. Ring*

Licensed Embalmer No. *4863*

P. O. Address *7027*

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.