

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-026864  
State File No.

FILED VS JUL 30 1959

2 6744  
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. <b>2 6744</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>5602 Columbia Ave.</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>MICHAEL</b>		b. (Middle) <b>ANTHONY</b>		c. (Last) <b>KRULL</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>July 18 1959</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>		8. DATE OF BIRTH <b>July 17, 1959</b>	
9. AGE (In years last birthday) <b>0</b>		IF UNDER 1 YEAR Months <b>0</b>		IF UNDER 1 YEAR Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Robert Krull</b>			13b. MOTHER'S MAIDEN NAME <b>Kay Oldendorph</b>			14. NAME OF HUSBAND OR WIFE <b>-----</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Robert Krull 5602 Columbia Ave.</b>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Prematurely labor</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Same</b>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>776x</b>				INTERVAL BETWEEN ONSET AND DEATH <b>12hr.</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____		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 <b>7-17, 1959</b> , to <b>7-18, 1959</b> , that I last saw the deceased alive on <b>7-18, 1959</b> , and that death occurred at <b>10:45 A.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>R. K. Koshu M.D.</b> (Degree or title)				23b. ADDRESS <b>35th Central Clayton</b>		23c. DATE SIGNED <b>7/19/59</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>July 20, 1959</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>	
DATE REC'D BY LOCAL REG. <b>JUL 20 1959</b>		REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Kriegshauser 4228 S. Kingshighway Bl.</b>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *R. W. Storrs*.....

Licensed Embalmer No. *4007*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.