IRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

59–030560

STATE FILE NUMBER

FILED VS AUG 27 1959

Local Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 7446

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS MO.
Length of stay in 1b
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): ST. LOUIS CITY HOSP #1
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4059 Shenandoah
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: VERNA Middle: A. Last: KRAUSHARR
4. DATE OF DEATH: Month 8 Day 9 Year 59
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: Mar. 24, 1911
9. AGE (last birthday): 48
IF UNDER 1 YEAR: Months 4 Days 15
IF UNDER 24 HR: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cashier
10b. KIND OF BUSINESS OR INDUSTRY: Strassberger Hall
11. BIRTHPLACE (City and state or country): St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Martin G. Ehret
13b. MOTHER'S MAIDEN NAME: Flora E. Mueller
14. NAME OF HUSBAND OR WIFE: Conrad Kraushaar
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 487-26-0064
17. INFORMANT: Conrad Kraushaar Address: 4059 Shenandoah

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): Congestive Heart Failure
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Rheumatic Heart Disease
DUE TO (c): 416x
INTERVAL BETWEEN ONSET AND DEATH

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

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

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

BY AFFIDAVIT OF

21. I attended the deceased from 7-26-59, to 8-9-59 and last saw her/him alive on 8-9-59
Death occurred at 12:15 pm m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: R. G. Kloecker (Degree or title) M. D.
22b. ADDRESS: 1515 Lafayette Ave
22c. DATE SIGNED: 8-10-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Aug. 12, 1959
23c. NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, County, Mo.

24. FUNERAL DIRECTOR: Schumacher's ADDRESS: 3013 Meramec St.
25. DATE RECD. BY LOCAL REG.: AUG 11 '59
26. REGISTRAR'S SIGNATURE: Hoard Smith M.D. M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by r

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Jack Haupt

Licensed Embalmer No. 4246

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.