URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH 59-033998

FILED VS OCT 15 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 8997 STATE FILE NUMBER

IENDED

1. PLACE OF DEATH
a. COUNTY ST LOUIS
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI — Length of stay in 1b 2 WKS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE ILLINOIS b. COUNTY JACKSON
c. CITY OR TOWN CARBONDALE — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 1309 W. COLLEGE — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First ALFRED Middle WILLIAM Last KRUMREICH
4. DATE OF DEATH Month SEPTEMBER Day 29 Year 1959

5. SEX MALE
6. COLOR OR RACE WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH 5-22-19
9. AGE (last birthday) 40 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER
10b. KIND OF BUSINESS OR INDUSTRY STATE HIGHWAY
11. BIRTHPLACE (City and state or country) TERRE HAUTE, IND.
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME HENRY KRUMREICH
13b. MOTHER'S MAIDEN NAME LULA HAGERDON
14. NAME OF ~~HUSBAND OR~~ WIFE GERTRUDE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) WW. II
16. SOCIAL SECURITY NO. 304-18-2224
17. INFORMANT Mrs G. Krumreich Address Carbondale Ill

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CARDIAC FAILURE	2-3 HOURS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	POST-OPERATIVE REPAIR OF MITRAL STENOSIS	1 DAYS
DUE TO (c)	RHEUMATIC HEART DISEASE 410 x	5 YEARS

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

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

21. I attended the deceased from JULY 13, 1955, to SEPT. 29, 1959 and last saw her/him alive on SEPT. 29, 1959
Death occurred at 7:35 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C. O. Vermillion, M.D. M.D.
22b. ADDRESS BARNES HOSPITAL
22c. DATE SIGNED 9/30/59

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE 9/30/59
23c. NAME OF CEMETERY OR CREMATORY
23d. LOCATION (City, town, or county) CARBONDALE (State) ILLINOIS

24. FUNERAL DIRECTOR DRAKE ADDRESS BENTON, ILL.
25. DATE RECD. BY LOCAL REG. SEP 30 '59
26. REGISTRAR'S SIGNATURE Earl Smith, M.D. MJB

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

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_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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