

URU DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 16 1959

59-034625

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 543 Registrar's No. 2414

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Louis | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Jennings | | Length of stay in 1b 5 Years | | c. CITY OR TOWN Jennings | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2620 McLaren Ave. | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 2520 McLaren Ave. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Arthur Fred Krausse | | | | 4. DATE OF DEATH Month <u>9</u> Day <u>7</u> Year <u>59</u> | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 1-30-74 | 9. AGE (last birthday) 85 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard | | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | | 11. BIRTHPLACE (City and state or country) Germany | | 12. CITIZEN OF WHAT COUNTRY USA |
| 13a. FATHER'S NAME Unknown | | | 13b. MOTHER'S MAIDEN NAME Unknown | | | 14. NAME OF HUSBAND OR WIFE Anne Krausse | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give year or dates of service) NO | | | 16. SOCIAL SECURITY NO. 499-34-6426A | 17. INFORMANT Address Walter A. Scott Ferguson, Mo. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Arteriosclerotic Heart disease DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days over 4 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fracture right hip 2 wks due to osteoporosis | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. | | Month, Day, Year _____ | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <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 <u>May 9, 1955</u> to <u>Sept 7, 1959</u> and last saw him alive on <u>Sept 7, 1959</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) Lewis Littmann MD | | | | 22b. ADDRESS 8231 Clayton Rd (17) | | 22c. DATE SIGNED 9/8/59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE 9-9-59 | 23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory | | 23d. LOCATION (City, town, or county) St. Louis, County, Mo. | | (State) |
| 24. FUNERAL DIRECTOR ADDRESS White-Mullen 118 N. Florissant Rd. | | | | 25. DATE RECD. BY LOCAL REG. 9-8-59 | | 26. REGISTRAR'S SIGNATURE J. C. Murphy M.D. | |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Gettison
8210*

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 *my-self* _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Reinhold K. Lohmann*

Licensed Embalmer No. *3395*

P. O. Address *St Louis 35*

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.