

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-038493

XC-16487863 Reg. #a-339ED VS OCT 19 1959

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2695

UNDECEASED

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Washington	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JEFFERSON BARRACKS, MO.	Length of stay in 1b 54 days	c. CITY OR TOWN OAKDALE	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADM. HOSPITAL	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Route #1	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First HERMAN Middle E. Last KROENER	4. DATE OF DEATH Month 10 Day 10 Year 59
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5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-6-95	9. AGE (last birthday) 64 YEARS	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY Agriculture	11. BIRTHPLACE (City and state or country) Oakdale, Ill.	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME FREDERICK KROENER	13b. MOTHER'S MAIDEN NAME LOUISE RANKEN	14. NAME OF HUSBAND OR WIFE SARAH E. KROENER
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT VA HOSPITAL RECORDS, JEFF. BRKS. 25 MO.
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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		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE	
	DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) HYPERTENSIVE VASCULAR DISEASE		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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 VA	COUNTY _____ STATE _____
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21. <input checked="" type="checkbox"/> attended the deceased from 8-17-59 to 10-10-59 Death occurred at 9:50 PM on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <i>W. Oppler</i> (Degree or title) DR. W. OPPLER, M.D., Director Professional Services, VA HOSP., JEFF. BRKS., MO.	22b. ADDRESS VA HOSP., JEFF. BRKS., MO.	22c. DATE SIGNED 10-10-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 10-11-59	23c. NAME OF CEMETERY OR CREMATORY OAKDALE	23d. LOCATION (City, town, or county) (State) OAKDALE ILLINOIS
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24. FUNERAL DIRECTOR PYATT	ADDRESS Pineknayville, Ill.	25. DATE RECD. BY LOCAL REG. 10-11-59	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 Frank Proloff

Licensed Embalmer No. 4356

P. O. Address St. Louis, Mo.

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.