

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042115

FILED VS DEC 7 1959

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **210444**

AMENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 5 days	c. CITY OR TOWN Carsonville Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION De Paul Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 8718 Weldon Ave. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First William Middle Krommueller Last			4. DATE OF DEATH Month 11 Day 11 Year 59		
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 5/10/1900	9. AGE (last birthday) 59	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker-Ret.		10b. KIND OF BUSINESS OR INDUSTRY Sheet Metal	11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME William Kronmueller		13b. MOTHER'S MAIDEN NAME Lena Blattner		14. NAME OF HUSBAND OR WIFE Florence Krommueller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 493-20-8470	17. INFORMANT Address 8718 Mrs. Florence Krommueller Weldon		

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 48 hrs
IMMEDIATE CAUSE (a)	Myocardial Infarction	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	Arteriosclerosis of Heart Disease	
	DUE TO (b)	years
	DUE TO (c)	years
		Generalized Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Pulmonary Embolism x 2		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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. INCIDENT <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.) 420-0
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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	COUNTY	STATE
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21. I attended the deceased from March 11, 1959 to Nov. 1959 and last saw him alive on 11/11/59
Death occurred at 3:45 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John B. Meyer - M.D.	22b. ADDRESS 634 N. Grand Blvd.	22c. DATE SIGNED 11/14/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 11/14/59	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Mausoleum	23d. LOCATION (City, town, or county) St. Louis County Mo.
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24. FUNERAL DIRECTOR Drehmann-Harral	ADDRESS 1905 Union	25. DATE RECD. BY LOCAL REG. NOV 13 1959	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

01. 2-3888

Hrs. 1 - 6 Thurs. & Fri.

Also De Paul Hospital

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 Warren A. Carver

Licensed Embalmer No. 3534

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.