

**MRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-017032**

FILED VS APR 29 1960

2 3850

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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 <b>ST. LOUIS</b>		Length of stay in 1b	c. CITY OR TOWN <b>LEMAY</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ALEXIAN BROS HOSP</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>316 SOUTHAMPTON</b>
		Yes <input type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First <b>WILLIAM</b>	Middle <b>KROUPA</b>	Last	Month <b>APRIL</b>	Day <b>4</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG 4 1888</b>	9. AGE (last birthday) <b>71</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED DAY LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>BONEMIA</b>		12. CITIZEN OF WHAT COUNTRY <b>U - S - A</b>
13a. FATHER'S NAME <b>ANTON KROUPA</b>		13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE <b>ROSE KROUPA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>489-03-0527</b>		17. INFORMANT <b>ROSE KROUPA 316 SOUTHAMPTON</b>	

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) <b>Pneumonia</b>		<b>12 hrs</b>
DUE TO (b) <b>Malnutrition</b>		<b>6-10 mo.</b>
DUE TO (c) <b>Cerebral arterio sclerosis &amp; Sclerosis</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>334x</b>		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 **3-2-60** to **4-4-60** and last saw <sup>her</sup>him alive on **4-4-60**  
 Death occurred at **4-4-60 7:30 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE <i>[Signature]</i> (Degree or title)		22b. ADDRESS <b>2623 Telegraph</b>	22c. DATE SIGNED <b>4-6-60</b>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>APR. 7 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION CEM</b>	23d. LOCATION (City, town, or county) <b>ST. LOUIS</b>
24. GENERAL DIRECTOR <b>Thomas Katis 2906 Gravois</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>APR 7 1960</b>	26. REGISTRAR'S SIGNATURE <b>Walter Smith, M.D.</b>

*m86*

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 \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *James C. [Signature]*

Licensed Embalmer No. 4347

P. O. Address 2906 [Address]

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