

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-021175

FILED VS. MAY 25 1960

318

1003

5046

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE <i>MO.</i> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS</i>		Length of stay in 1b <i>53 YRS.</i>		c. CITY OR TOWN <i>ST. LOUIS</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>4237 N. FLORISSANT.</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>4237 N. FLORISSANT</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>JOHANNA</i> Middle <i>A.</i> Last <i>KREY</i>				4. DATE OF DEATH Month <i>MAY</i> Day <i>12</i> Year <i>1960</i>				
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>7-9-1884</i>	9. AGE (last birthday) <i>75</i>	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) <i>NONE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOUSEWIFE</i>		11. BIRTHPLACE (City and state or country) <i>PIQUA, OHIO</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>		
13a. FATHER'S NAME <i>JACOB GROTH</i>			13b. MOTHER'S MAIDEN NAME <i>WILHELMINA CRONER</i>		14. NAME OF HUSBAND OR WIFE <i>HENRY KREY</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>MARJORIE KREY</i> Address <i>4237 N. FLORISSANT</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Arterio-sclerosis</i> DUE TO (c) <i>Hypertensive heart disease</i>						INTERVAL BETWEEN ONSET AND DEATH <i>one hour</i> <i>2 1/2 yrs +</i> <i>2 1/2 yrs +</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>443X</i>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 <i>Oct 1, 1957</i> to <i>May 12, 1960</i> and last saw her <i>alive on May 2, 1960.</i> Death occurred at <i>5:20 A.M.</i> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>D. E. J. [Signature]</i> (Degree or title) <i>MO</i>				22b. ADDRESS <i>4222 N. Grand</i>		22c. DATE SIGNED <i>5-13-60</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>MAY 14, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>FRIEDENS CEM.</i>		23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS, MO.</i>			
24. FUNERAL DIRECTOR <i>SUED MEYER & SONS</i> ADDRESS <i>3934 N. 20TH ST.</i>			25. DATE RECD. BY LOCAL REG. <i>MAY 13 1960</i>		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i> <i>mrc</i>			

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 Robert M. Howard

Licensed Embalmer No. 3749

P. O. Address 17 Lincoln

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.