

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-032489

FILED VS SEP 2 1960 **318**

Primary Registration District No. **1003**

Registrar's No.

8386

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b years		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4328 Gano A venue			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4328 Gano Avenue			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Edward Middle F Last Krewinghaus				4. DATE OF DEATH Month August Day 25 Year 1960			
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 2-17-1875	9. AGE (last birthday) 85	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) Secretary (retired)			10b. KIND OF BUSINESS OR INDUSTRY Thomas Wright Inv Co		11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Ernst Krewinghaus			13b. MOTHER'S MAIDEN NAME Sophia Schnadtthorst			14. NAME OF HUSBAND OR WIFE deceased	
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. _____		17. INFORMANT Address Mrs. Genevieve Cull, 4328 Gano Avenue		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute gastroenteritis</u> DUE TO (b) <u>virus infection</u> DUE TO (c) <u>senile changes</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 571.1					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>Aug 15 1960</u> to <u>Aug 25 1960</u> and last saw ^{DEK} him alive on <u>Aug 28 1960</u> Death occurred at <u>Aug 25 1960 9:30A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Joseph Davis M.D.</u>				22b. ADDRESS <u>4615 Lindell Bl</u>		22c. DATE SIGNED <u>Aug 25 1960</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug 29 1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Missouri		
24. FUNERAL DIRECTOR ADDRESS Math Hermann & Son, Inc., 2161 E. Fair Av				25. DATE RECD. BY LOCAL REG. AUG 26 1960		26. REGISTRAR'S SIGNATURE <u>Loed Smith M.D.</u>	

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 _____
Glenn W. Hat

Licensed Embalmer No. 433

P. O. Address St. Louis

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.