

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-036786

FILED VS SEP 19 1960

317

Primary Registration District No. 544

Registrar's No. 2624

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST LOUIS</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BIRKWOOD</u>		Length of stay in lb <u>4 DAYS</u>		c. CITY OR TOWN <u>CHESTERFIELD</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOSEPH</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>H1 # 109</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>Kranung</u> Last <u>Kranung</u>				4. DATE OF DEATH Month <u>9</u> Day <u>4</u> Year <u>60</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3/31/1877</u>	9. AGE (last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (City and state or country) <u>ST. LOUIS CO. MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>DAMIAN KRANUNG</u>			13b. MOTHER'S MAIDEN NAME <u>ELIZABETH STEFFAN</u>			14. NAME OF HUSBAND OR WIFE <u>DORA SOPHIE KRANUNG</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>493-42-7039</u>		17. INFORMANT <u>Mrs Sophie Kranung, Chesterfield, Mo</u>			Address
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) <u>ACUTE MESENTERIC THROMBOSIS</u>							<u>3 Hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>GENERALIZED ARTERIO SCLEROSIS</u>							<u>20 years</u>	
DUE TO (c) <u> </u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown			
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.)				
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		Month, Day, Year <u> </u> <u> </u> <u> </u>						
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>9-1-60</u> to <u>9-4-60</u> and last saw ^{her} <u>him</u> alive on <u>9-3-60</u>				Death occurred at <u>7:30</u> <u>A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Degree or title) <u>Dale H. Blankenship M.D.</u>				22b. ADDRESS <u>Ballwin Mo.</u>		22c. DATE SIGNED <u>9-6-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>9-6-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GUMBO CEM.</u>		23d. LOCATION (City, town, or county) <u>GUMBO, MO</u>		(State)	
24. FUNERAL DIRECTOR <u>SCHRADER, BALLWIN, MO</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>9-6-60</u>		26. REGISTRAR'S SIGNATURE <u>J. C. Massey 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 Richard Bupp

Licensed Embalmer No. 458

P. O. Address Baltimore

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.