

DATE AMENDED

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **4120**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. ANTHONY HOSPITAL		d. STREET ADDRESS (If outside, give location) 5000 So. BROADWAY	

3. NAME OF DECEASED (Type or print) First EMMA Middle KREN Last	4. DATE OF DEATH Month APRIL Day 30 Year 1961
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5. SEX FEMALE	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 OCT 8 1881	9. AGE (last birthday) 79	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and state or country) ILLINOIS	12. CITIZEN OF WHAT COUNTRY U-S-A
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13a. FATHER'S NAME WILLIAM BRABETZ	13b. MOTHER'S MAIDEN NAME UNK	14. NAME OF HUSBAND OR WIFE MATTHEW KREN (DECD)
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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. NONE	17. INFORMANT MARION KREN 3394 TEDMAR
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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) ACUTE CARDIAC FAILURE		1 1/2 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE	11 YRS.
	DUE TO (c) 443X	

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 checked="" 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. 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.)
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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
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21. I attended the deceased from **8-1-50** to **4-30-61** and last saw her ^{her} _{him} alive on **4/30/61**
 Death occurred at **11 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Henry Cooper M.D.	22b. ADDRESS 818 Olive St.	22c. DATE SIGNED 5/1/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE MAY 3, 1961	23c. NAME OF CEMETERY OR CREMATORY SUNSET BURIAL PARK	23d. LOCATION (City, town, or county) (State) ST. LOUIS MO.
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FUNERAL DIRECTOR Thomas Kutis 2906 Gravois	25. DATE RECD. BY LOCAL REG. MAY 1 1961	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.
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DOCUMENT

MEDICAL CERTIFICATION

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 James C. Hill

Licensed Embalmer No. 43471

P. O. Address 2906 Francis

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.