SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

MENT OF PUBLIC HEALTH AND WELFARE

-61-042616

STATE FILE NUMBER

Registration District No. XC 2189598 Primary Registration District No. SL 26958 Registrar's No. 10607

318 1003

FILED NOV 28 1961

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY Franklin

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO. Length of stay in 1b 17 DAYS

c. CITY OR TOWN SULLIVAN Inside Limits Yes X No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, ST. LOUIS, MO. Inside Limits Yes X No ☐

d. STREET ADDRESS (If outside, give location) Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print) First JAMES Middle J Last KRONINGER

4. DATE OF DEATH Month 11/13/61 Day Year

5. SEX MALE

6. COLOR OR RACE WHITE

7. Married ☐ Widowed XX Never Married ☐ Divorced ☐

8. DATE OF BIRTH 8/14/93

9. AGE (last birthday) 68 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) UNK

10b. KIND OF BUSINESS OR INDUSTRY --

11. BIRTHPLACE (City and state or country) COWDEN, ILL

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME UNK

13b. MOTHER'S MAIDEN NAME UNK

14. NAME OF HUSBAND OR WIFE --

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I

16. SOCIAL SECURITY NO. UNK

17. INFORMANT HELN HOOPER (SISTER) Address COWDEN, ILL.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) MULTIPLE PULMONARY EMBOLI

INTERVAL BETWEEN ONSET AND DEATH 5 DAYS

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Bleeding Gastric Ulcer

DUE TO (c) 540.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) BLEEDING GASTRIC ULCER, STAPHYCOCCAL PNEUMONIA, ACUTE MYOCARDIAL INFARCTION.

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES X NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. VA attended the deceased from 10/27/61, to 11/13/61 and last saw XX him alive on 11/13/61

Death occurred at 3:40 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] M.D.

22b. ADDRESS VAH, ST. LOUIS, MO.

22c. DATE SIGNED 11/14/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 11/17/61

23c. NAME OF CEMETERY OR CREMATORY Owaneco Cem.

23d. LOCATION (City, town, or county) (State) Owaneco, Ill.

24. FUNERAL DIRECTOR Lockhartason ADDRESS Shelbyville, Ill.

25. DATE RECD. BY LOCAL REG. NOV 15 1961

26. REGISTRAR'S SIGNATURE Carl Smith. M.D.

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 Not Embalmed, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John J. Kanly III

Licensed Embalmer No. 5039

P. O. Address St. Louis, Mo

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.