

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-047468

Registration District No. 319 Primary Registration District No. _____ Registrar's No. 60 STATE FILE NUMBER

AMENDED

FILED JAN 2 1962

1. PLACE OF DEATH a. COUNTY <u>ST. GENEVIEVE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST. GENEVIEVE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>BEAUVIS T.S.</u>		Length of stay in 1b <u>69 yrs</u>	c. CITY OR TOWN <u>ST. GENEVIEVE RR#1</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. GENEVIEVE MO RR#1</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>RR#1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>CATHERINE</u> Middle <u>KRAENZLE</u> Last _____	4. DATE OF DEATH Month <u>DEC</u> Day <u>25</u> Year <u>1961</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/19/74</u>	9. AGE (last birthday) <u>87</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>ZELL MO</u>	12. CITIZEN OF WHAT COUNTRY <u>USA.</u>
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13a. FATHER'S NAME <u>WILLIAM NARLER</u>	13b. MOTHER'S MAIDEN NAME <u>MARY SCHWEISS</u>	14. NAME OF HUSBAND OR WIFE <u>ANDREW KRAENZLE</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT Address <u>RR#1</u> <u>Leo Kraenzle St. Genevieve Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u>	DUE TO (b) <u>arteriosclerosis</u>	<u>2</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) <u>bronchial pneumonia</u>	<u>7 days</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"/> 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.)
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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 Nov 2, 1960 to Dec 25, 1961 and last saw her alive on Dec 24, 1961
Death occurred at 7:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Dr. Lansing M.D.</u> (Degree or title)	22b. ADDRESS <u>St. Genevieve Mo</u>	22c. DATE SIGNED <u>12/26/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>DEC 27 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>	23d. LOCATION (City, town, or county) (State) <u>OLORA MO</u>
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24. FUNERAL DIRECTOR <u>Geo. C. Bach Sr. St. Genevieve Mo</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>27 December 1961</u>	26. REGISTRAR'S SIGNATURE <u>George F. Wood</u>
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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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Adrian J. Eller

Licensed Embalmer No. 4740

P. O. Address St. Bernard

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.