

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-032624

DO NOT WRITE ON THIS STUB

AMENDED

Registration District **318** Primary Registration District **1003** Registrar's No. **8317**

STATE FILE NUMBER

VS 300 Rev. 4/59

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2 22 1/2  
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12 76.0  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS (INSTEAD OF)

76

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Length of stay in 1b <b>2 MO'</b>	c. CITY OR TOWN <b>ST. LOUIS</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>CHRONIC HOSP.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2900 INDIANA</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>JACOB G. KRAUSE</b>			4. DATE OF DEATH Month Day Year <b>8 26 62</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/20/81</b>
9. AGE (last birthday) <b>81</b>		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) <b>maintenance man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Holdenreid Carpet Co. MO' (St. Louis)</b>	
11. BIRTHPLACE (City and state or country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <b>JOHN Krause</b>		13b. MOTHER'S MAIDEN NAME <b>Grueninger BARBARA MARGARET</b>	
14. NAME OF HUSBAND OR WIFE <b>-----</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Henry Krause - 4508 S. Compton</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> DUE TO (b) <b>Undetermined Organism</b> DUE TO (c) <b>491X</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Arteriosclerotic Heart Disease</b>			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 <b>6-20-62</b> , to <b>8-26-62</b> and last saw her/him alive on <b>8-26-62</b> Death occurred at <b>12:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Don Huggins, M.D.</b> (Degree or title)		22b. ADDRESS <b>634 N. Grand</b>	22c. DATE SIGNED <b>8-27-62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>Aug. 28, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Missouri Crematory</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
24. FUNERAL DIRECTOR <b>WACKER-HELDERLE-3634 Gravois Ave.</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>AUG 27 1962</b>	26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b>

**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 *[Handwritten Signature]*  
711 Bello

Licensed Embalmer No. 4375  
P.O. Address *[Handwritten Address]*

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.