

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

2946-63-038351
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2946

FILED OCT 10 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY ST. CLAIR	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN JEFFERSON BARRACKS, MO.		Length of stay in 1b 2494 DAYS	c. CITY OR TOWN BELLEVILLE Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 117 WEST MONROE STREET Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALBERT Middle L. Last KROENIG			4. DATE OF DEATH Month 9 Day 21 Year 1963
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5-11-1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOE WORKER		10b. KIND OF BUSINESS OR INDUSTRY SHOE INDUSTRY	9. AGE (last birthday) 73 YRS IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HR: Months Days Hours Min.
11. BIRTHPLACE (City and state or country) BELLEVILLE, ILLINOIS		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME JOSEPH KROENIG		13b. MOTHER'S MAIDEN NAME WILHELMINA KOHLER	14. NAME OF HUSBAND OR WIFE NEVER MARRIED
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) YES WW-I		16. SOCIAL SECURITY NO. NEXT OF KIN HENRY KROENIG, 1612 DUNCAN BELLEVILLE, ILL.	
18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA-UNKNOWN ETIOLOGY DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 48 HRS 5 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ARTERIOSCLEROSIS, GENERAL			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.) VA		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. attended the deceased from 11-23-56 to 9-21-63 Death occurred at 10:00 AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Print name and title) EUGENE L. ARNOLD M.D.		22b. ADDRESS VA HOSP. JEFF. BRKS. MO.	22c. DATE SIGNED 9-21-63
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE 9-24-63	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.
24. FUNERAL DIRECTOR ADDRESS Gaerdner Funeral Home, Belleville, Ill.		25. DATE RECD. BY LOCAL REG. 9-23-63	26. REGISTRAR'S SIGNATURE John B. Minfley M.D.

USE BLACK INK OR TYPEWRITER RIBBON

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 _____

No Embalm

Licensed Embalmer No. _____

P. O. 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.