

FILED MAY 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17434**
Registrar's No. **4589**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE		b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give OR TOWN) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) Mt. Olive		d. STREET ADDRESS (If rural, give location) U.R.		
d. FULL NAME OF HOSPITAL OR INSTITUTION Model Hotel 15th & Market		c. LENGTH OF STAY (in this place) 3		9 4 11		
3. NAME OF DECEASED a. (First) Louis			b. (Middle) A.			
c. (Last) Kruse			4. DATE OF DEATH (Month) (Day) (Year) May 23 1949			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 7, 1891	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commissary Depot	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Mt. Olive, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S. A.		
13a. FATHER'S NAME William Kruse		13b. MOTHER'S MAIDEN NAME Sophia Mindrun		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW # 1		17. INFORMANT'S SIGNATURE OR NAME William Kruse		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Aortic Stenosis DUE TO (c) Chronic Coronary II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Sclerosis			INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 92		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4211				
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1000 A.M. , from the causes and on the date stated above.						
23a. SIGNATURE Patrick E. Taylor		23b. ADDRESS 31300 Clark		23c. DATE SIGNED 5-24-49		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal via Motor	24b. DATE May 25, 1949	24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	24d. LOCATION (City, town, or county) (State) Mt. Olive Illinois			
DATE REC'D BY LOCAL REG. MAY 24 1949	REGISTRAR'S SIGNATURE J. B. Basater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Math. Hermann & Son, Inc. 2161 E. Fair Av				

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

9-17

66-2170

JUL 12 1948

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
Student Embalmer

Signed *Walter B. Bussley*

Licensed Embalmer No. *4303*

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 this body is not embalmed, fact should be so stated above.