MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

13346

1. PLACE OF DEATH

County ..... Registration District No. 791 1003

Township ..... Primary Registration District No. .....

City St. Louis (No. City Hospital ..... St. ..... Ward)

File No. .....

Registered No. 3916

2. FULL NAME 1937 Elizabeth Kraft

(a) Residence. No. 2318 Dalina St., 23 Ward.
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 17 1844

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ___ hrs. or ___ min.
	84	8	12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

235

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Missouri

1

PARENTS

10. NAME OF FATHER Frederick Skinner

10

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Germany

12. MAIDEN NAME OF MOTHER Unknown

31

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... "
(STATE OR COUNTRY) Hospital Informant

14. INFORMANT C. Kraft
(Address) City Hospital

15. FILED ..... 1929 Max C. Starkey
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 29 1929

17. I HEREBY CERTIFY, That I attended deceased from March 24, 1929, to March 29, 1929, that I last saw him alive on March 29, 1929, and that death occurred, on the date stated above, at 11:35 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Senility
Ch. Myocarditis
Ch. Nephritis
..... (duration) ? yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 129a
..... (duration) ..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? No
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? R. Berg
(Signed) ..... M. D
3/30, 1929 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
New St. Marcus	4-1-1929
20. UNDERTAKER	ADDRESS
W. Schumacher	3013 Meramec

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

THIS IS A PERMANENT RECORD

Kraft.