

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

Do not use this space.

35062

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **11103**

City **St. Louis** (No. **St. Johns Hosp.**)

File No.....

Registered No. **9771**

St. Ward)

2. FULL NAME

Heure Kraft

(a) Residence. No. **Blodgett Mo.** St. **12** Ward. **Blodgett Mo**
(Usual place of abode)

Blodgett Mo
(If nonresident give city or town and State)

Length of residence in city or town where death occurred **20** yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Feb. 26th 1880**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
49 7 6

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Illinois**

10. NAME OF FATHER **John Kraft.**

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

12. MAIDEN NAME OF MOTHER **Mary Laub.**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **Germany**

14. INFORMANT (Address) **John Kraft 3748 Laclede Ave**

15. FILED **Mad. b. Stankoff** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) **Oct. 2nd 1929**

17. I HEREBY CERTIFY That I attended deceased from **May 19 1929** to **Oct 2 19 29** that I last saw h. **alive on Oct 2 19 29**, and that death occurred, on the date stated above, at **9 15/4 a.m.**

18A. THE CAUSE OF DEATH WAS AS FOLLOWS:

97
10-2 **Cerebral Haemorrhage (apoplexy)**

CONTRIBUTORY (SECONDARY) **hyp. blood P. chronic atherosclerosis**

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? **no** DATE OF...
WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **all tests**
(Signed) **Chas. Hays, M.D.**

193, 19 **29** (Address) **Heurbeck Rd**

*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 **Sikeston, MO** DATE OF BURIAL **10-4 1929**

20. UNDERTAKER **F. Schumacher** ADDRESS **3013 Meramec**

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

Humboldt Bay

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