

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

Do not use this space.

31168

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1903**

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

File No.

Registered No. **8757**

2. FULL NAME

Clara E. Kraus

(a) Residence. No. **3447** **Taska** St. **15** Ward. (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **3-10-1880**

7. AGE YEARS MONTHS DAYS IF LESS than I day, hrs. or min. **50 5 25**

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

9. BIRTHPLACE (CITY OR TOWN) **St. Louis** (STATE OR COUNTRY) **Mo.**

10. NAME OF FATHER **Geo. Clemens**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Mo.**

12. MAIDEN NAME OF MOTHER **Alvena Meier**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) **St. Louis Mo.**

14. INFORMANT **Johas. Kraus** (Address) **3447 Taska**

15. REGISTERED **My C. Harber**

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **9-4-30**

17. **No** Physician attended **I HEREBY CERTIFY, That I attended deceased from**

....., 19....., to 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hemorrhage of Brain
2105 (Graben St.)
fall from auto in
21050 Bismark Mo. Mo. Mo.

CONTRIBUTORY (SECONDARY) **Accident**

18. WHERE WAS DISEASE CONTRACTED **1880** IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY **Yes**

WHAT TEST CONFIRMED DIAGNOSIS..... (Signed) **Wm. V. Dewar M.D.** 19**30** (Address) **Coroner**

*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 **Sunset Burial Park** DATE OF BURIAL **Sept. 8 19 30**

20. UNDERTAKER **Amminator Funder** ADDRESS **7128 Michigan**

WHITE 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.

SEP 10 1930

