

LEG. NOV 16 1938

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

33686  
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. **791**  
(b) Township..... Primary Registration District No. **1003** Registered No. **8672**  
(c) City *St Louis Mo* (d) Street No. *Deaconess Hospital* St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. *7417 Virginia Ave* St. **1** (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 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 *Anna Kraft*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Feb 16 - 1858*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
*80 7 15*

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc. *None*  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ill.*

FATHER 13. NAME *Unknown Kraft*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

MOTHER 15. MAIDEN NAME *Huffman*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ill.*

17. INFORMANT (ADDRESS) *Jubing Kraft St Louis Mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Park Lawn* DATE *Oct 4 - 38*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Penick Med Co 7420 Michigan Ave*

20. FILED **OCT 4 1938** *J. G. Brebeck* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct 1 1938*

22. I HEREBY CERTIFY, That I attended deceased from *9-2-38* to *10-1-38*

I last saw him alive on *10-1-38*... Death is said to have occurred on the date stated above, at *8 p.* m.

The principal cause of death and related causes of importance were as follows:

*Hemiplegia caused by hypertension*  
*Diabetes*  
*137*

Date of onset *10-1-38*

Other contributory causes of importance:  
*Cystostomy for hypertrophy of prostate*

Name of operation..... Date of.....  
What test confirmed diagnosis..... Was there an autopsy *yes*

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?  
If so, specify.....

(Signed) *W. W. Cade*, M. D.

(Address) *7310 Michigan*

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.

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 \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signature

Licensed Embalmer No. 2679

P. O. Address 744 Gungung

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, above space should be left blank.