

REC'D MAR 13 1939

## MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH791  
1003

4952

Do not use this space.

1645

## 1. PLACE OF DEATH

(a) County ..... Registration District No. ....  
 (b) Township ..... Primary Registration District No. ....  
 or .....  
 (c) City *St. Louis mo* ..... (d) Street No. *St. Anthony 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. *4672 A Tennessee Ave* St. *15*  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*  
 4. COLOR OR RACE *white*  
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *single*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan. 10 1927*  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
*12 10 1 10*  
 OCCUPATION  
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *School Boy*  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 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) *St. Louis mo*  
 FATHER  
 13. NAME *George Kraft*  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis mo*  
 MOTHER  
 15. MAIDEN NAME *Helen Wodicka*  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis mo*  
 17. INFORMANT (ADDRESS) *Helen Kraft - 4672 Tennessee Ave*  
 18. BURIAL, CREMATION, OR REMOVAL PLACE DATE *St. Peter Paul Feb 23 1939*  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Thos. Kuti's 2906 Brooks Ave*  
*J. P. Brubaker*  
 Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb. 20 1939*22. I HEREBY CERTIFY, That I attended deceased from *Feb. 13 1938*, to *Feb. 20 1939*

I last saw him alive on *Feb. 19 1939*. Death is said to have occurred on the date stated above, at *7 A. M.*  
 The principal cause of death and related causes of importance were as follows:

*Peritonitis & multiple intestinal perforations & abscesses of vol. rotulus (partial)*

Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....  
*W*What test confirmed diagnosis? *Autopsy*. Was there an autopsy? *Yes*23. If death was due to external cause (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? *No*

If so, specify .....

(Signed) *A. F. Plog* M. D.(Address) *3132 Morganford Rd.*20. FILED *19*  
**FEB 20 1939**

(Licensed Embalmer's Statement on Reverse Side)

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.....

*Thos Luteis*

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Thos Luteis*

Licensed Embalmer No. ~~2906~~ *1619*

P. O. Address *2906 Gravois*

**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.**