

Registration District No. 7914

Primary Registration District No. 1003

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
 (b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
City Hospital, #1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 Mo.  
(Specify whether years, months or days)  
 In this community 31 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 3225 Montgomery  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? Unknown years.

8. (a) PRINT FULL NAME Adam Kramer

8. (b) If veteran, name war Unknown  
 8. (c) Social Security No. Unknown

4. Sex Male  
 5. Color or race White  
 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife Unknown  
 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased August 1, 1880  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>59</u>	<u>7</u>	<u>6</u>	hr. _____ min. _____

9. Birthplace \_\_\_\_\_ Germany  
(City, town, or county) (State or foreign country)

10. Usual occupation Nil.

11. Industry or business Nil.

MOTHER FATHER { 12. Name Sam Kramer

13. Birthplace \_\_\_\_\_ Germany  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Kramer ??

15. Birthplace \_\_\_\_\_ Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Anna Kramer  
 (b) Address City Hospital, #1

17. (a) \_\_\_\_\_ (b) Date thereof 3/10/40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director W. Richter  
 (b) Address 3500 Rutger  
MAR 29 1940

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 1,  
 year 1940 hour 8:15 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from February  
1, 1940 to March 1, 1940;  
 that I last saw him alive on March 1, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Calculation of Face  
 Duration 2 hrs

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions U.C.N.S. Syphilis gran  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN  
 \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? \_\_\_\_\_ (Specify type of place)  
 (e) Means of injury \_\_\_\_\_

23. Signature Walter Ford (M. D. or other)  
 Address 1515 Lafayette Date signed 3/1/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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**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.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.**