

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
4163 CLEVELAND
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **Life** _____ (Specify whether
years, months or days) **112**

8. (a) PRINT FULL NAME **CLARA ORLEMANN KRAFT**

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

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

6. (b) Name of husband or wife **August Kraft** 6. (c) Age of husband or wife if alive **75** years

7. Birth date of deceased **April 4 1865**
(Month) (Day) (Year)

8. AGE: Years **75** Months **3** Days **26** If less than one day
hr. _____ min. _____

9. Birthplace **St. Louis Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Home**

12. Name **Jacob Orlemann**

13. Birthplace _____ **GERMANY**
(City, town, or county) (State or foreign country)

14. Maiden name **Philomena Kraus**

15. Birthplace _____ **GERMANY**
(City, town, or county) (State or foreign country)

16. (a) Informant **Beatrice Kraft**

(b) Address **4163 Cleveland Ave**

17. (a) **Burial** (b) Date thereof **Aug 1 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Valhalla Cemetery**

18. (a) Signature of funeral director **W. B. Probst U.C.**

(b) Address **217940 S. Jefferson Ave**

19. (a) _____ (b) **J. F. Bredeur**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County _____
(c) City or town **St Louis** **17**
(If outside city or town limits, write "RURAL")
(d) Street No. **4163 CLEVELAND**
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **30**
year **1940** hour **1** minute **10 A.** M.

21. I hereby certify that I attended the deceased from **July 25**
1940 to **July 30**, 19**40**
that I last saw her alive on **July 29**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral apoplexy**

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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

(a) Accident, suicide, or homicide (specify) **not**

(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 **N. W. Gilbert** (M. D. or other) **1**

Address **2739 N. Grand** Date signed **7-31-40**

Duration

5 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

Paul A. Shanklin

Registered Apprentice No.

working under my personal supervision.

Signed *Paul A. Shanklin*

Licensed Embalmer No. 3472

P. O. Address 2929 S. Jefferson

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.