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S. No. 2
4-13-40
5-17-39
15X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

34019

State File No. 8716

Registration District No. 791 Primary Registration District No. 1003 Registrar's No.

FILED NOV 16 1940

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

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: St. Louis City Hospital #1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 Days (Specify whether years, months or days)
In this community 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County
(c) City or town St. Louis 26 (If outside city or town limits, write "RURAL")
(d) Street No. 1523a S. 9th St. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Anna Kraus
3. (b) If veteran, name war ----
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife ----
6. (c) Age of husband or wife if alive --- years
7. Birth date of deceased July (Month) 1, (Day) 1873 (Year)

8. AGE: Years 67 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) Illinois (State or foreign country)
10. Usual occupation Home
11. Industry or business
MOTHER FATHER
12. Name Frank Kraus
13. Birthplace Unknown (City, town, or county) Germany (State or foreign country)
MOTHER
14. Maiden name Susie Gottschammer
15. Birthplace Unknown (City, town, or county) Illinois (State or foreign country)
16. (a) Informant Mrs. E. Grasear
(b) Address 1523 S. 9th St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/40 (Month) (Day) (Year)
(c) Place: burial or cremation N. St. Marcus
18. (a) Signature of funeral director Wacker-Heldeside
(b) Address 2331 S. Broadway
19. (a) OCT 22 1940 (Date received by local Registrar) (b) J. F. Bueck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 22,
year 1940 hour 8:15 minute A. M.
21. I hereby certify that I attended the deceased from October 19, 1940, to October 22, 1940; that I last saw her alive on October 22, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Left hemiplegia	4 days
Due to: Right Cerebral Hemorrhage	4 days
Due to: Generalized Arteriosclerosis	10 yrs.
Other conditions: Syphilis (Include pregnancy within 3 months of death)	?

PHYSICIAN

Major findings:
Of operations
Of autopsy none

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? (Specify type of place)
While at work (a) Means of injury

23. Signature E. A. Grasear, M.D. or other
Address 1515 Lafayette Avenue, Date signed 10/22/40

(Licensed Embalmer's Statement on Reverse Side)

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 Frank R. J. Wyland.

Licensed Embalmer No. 2645

P. O. Address St. Louis Mo

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, fact should be so stated above.