No. 2
11-10-39
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FILED NOV 21 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

36354

State File No.

Registration District No. 784 Primary Registration District No. 200 Registrar's No. 2068

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis, Missouri Lemay (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Mt. St. Rose Sanatorium 3 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

0

(d) Street No. 3245 Missouri Avenue (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Kratz, Otto

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Separated

6. (b) Name of husband or wife Anna

6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased December (Month) 30 (Day) 1877 (Year)

8. AGE: Years 62 Months 9 Days 23 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Horseshoer 6

11. Industry or business 1

FATHER
12. Name John Kratz
13. Birthplace (City, town, or county) Germany (State or foreign country)

MOTHER
14. Maiden name Anna Damm
15. Birthplace (City, town, or county) Germany (State or foreign country)

16. (a) Informant Charles Kratz

(b) Address 5203 Tennessee

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-40 (Month) (Day) (Year)

(c) Place: burial or cremation New St. Marcus

18. (a) Signature of funeral director Mat Engelhorn

(b) Address 7027 Gravois Ave.

19. (a) OCT 24 1940 (Date received local registrar) (b) R. Meyer M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 23 year 40 hour 8 minute 35 A.M.

21. I hereby certify that I attended the deceased from 2/6/ 1940 to 10/23/ 1940; that I last saw him alive on 10/23/ 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Far advanced Pulmonary Tuberculosis	1 yr
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: none	

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature C. E. Gerson (M. D. or other) 1

Address Mt. St. Rose Sanatorium Date signed 10-23-40

(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 C. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 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.