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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 19947

FILED JUL 21 1941 791  
Registration District No.

Primary Registration District No. 1003

Registrar's No. 4759

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

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:  
3874 Connecticut St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community 65 years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL") 1617  
(d) Street No. 3874 Connecticut Street  
(If rural, give location) 9  
(e) If foreign born, how long in U. S. A.? 65 years 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 6th  
year 1941 hour 2 minute 05 A. M.  
21. I hereby certify that I attended the deceased from about  
Jan 1941 to June 5 1941  
that I last saw him alive on June 5 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Bronchopneumonia  
carcinoma of prostate  
metastases to spine  
Due to arteriosclerosis, generalized  
Due to hypertension  
Other conditions  
(Include pregnancy within 3 months of death) \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Mr. Helwig Kraft

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

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

6. (b) Name of husband or wife Mary Holtgreve Kraft 6. (c) Age of husband or wife if alive 79 years

7. Birth date of deceased January 16th, 1858  
(Month) (Day) (Year)

8. AGE: Years 83 Months 4 Days 20 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Gardener

11. Industry or business Tower Grove Park

12. Name William Kraft

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

14. Maiden name Elizabeth Schwing

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

16. (a) Informant Mary Kraft  
(b) Address 3874 Connecticut St.

17. (a) Burial (b) Date thereof June 9, 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sunset Burial Park

18. (a) Signature of funeral director Beiderwieden F. H. Inc.

(b) Address 1936 St. Louis Avenue

19. (a) JUN 9 1941 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

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

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 Edward Mauer (M. D. or other) 0  
Address 607 N. Grand Ave Date signed 6/6/41

Dr. Edward M.  
Univ. Club B.  
3-5:30

**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. *3737*

P. O. Address *1936 N. Maple*

**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.**