No. 2
-4-13-40
5-17-39
I X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILLED OCT 28 1941

Registration District No. 791

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 30455

Registrar's No. 7794

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: Des Loge Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Three years 0 (Specify whether years, months or days)
In this community Three Years Three Months

2. USUAL RESIDENCE OF DECEASED: 18 999 11 0
(a) State Illinois (b) County
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Waterloo Route # 1
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 2 years.

3. (a) PRINT FULL NAME John Kraft
3. (b) If veteran, name war no
3. (c) Social Security No. no
4. Sex Male 0
5. Color or race white
6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Magdalene Kohnz
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug. 13 1863 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
78	1	14	hr. min.

9. Birthplace County Monros (City, town, or county) Illinois (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
MOTHER FATHER
12. Name Wilhelm Kraft
13. Birthplace (City, town, or county) Germany 4 (State or foreign country)
14. Maiden name Barbara Eschmann
15. Birthplace (City, town, or county) Germany 4 (State or foreign country)
16. (a) Informant Joseph Kraft
(b) Address 2854 Lemp Avenue
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30 '41 (Month) (Day) (Year)
(c) Place: burial or cremation Waterloo Illinois
18. (a) Signature of funeral director Thos Finan
(b) Address 1519 South Grand Blvd
19. (a) SEP 29 1941 (Date received local registrar) (b) J. F. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 27 year 41 hour 7 minute 15 M.
21. I hereby certify that I attended the deceased from 6/12/38, 19, to 9/27/41, 19; that I last saw him alive on 9/27/41, 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Pulmonary Edema
Hypostatic Bronchio Pneumonia 2 days
Due to Cardiac failure
Due to Hypertensive Heart Disease
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy Confirmed above

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) no
(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 Ray A. Meyers (M. D.)
Address 1325 S. Broadway Date signed 9/27/41

(Licensed Embalmer's Statement on Reverse Side)

DEPARTMENT OF COMMERCE
Bureau of the Census

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____ Primary Reg. District No. _____ Registrar's No. _____

1. PLACE OF DEATH:
(a) County _____
(b) City or town _____
(If within city or town limits, write "HOSPITAL" and name of town, city)
(c) Name of hospital or institution _____
(If in a hospital or institution, write street no. or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:
(a) State _____ (b) County _____
(c) City or town _____
(If within city or town limits, write "HOSPITAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____

3. (a) FIRST FULL NAME _____

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

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

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day: hr. _____ min.

9. Birthplace _____

10. Usual occupation _____

11. Industry or business _____

12. Birthplace _____ (State or foreign country), Registered Apprentice No. _____

13. Citizen of _____

14. Race _____

15. Father's name _____

16. Maiden name of mother _____

17. Place of birth _____

18. Address _____

19. Informant _____

20. DATE OF DEATH: Month _____ day _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19__ to _____ 19__; that I last saw him alive on _____ 19__ and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration

NOV 10 1950

Due to _____

Due to _____

MEDICAL CERTIFICATION

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)

23. Signature _____ (M. D. or coroner)

24. Address _____

25. Date signed _____ (Month) (Day) (Year)

26. If this body is not embalmed, fact should be so stated above.

(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 _____ working under my personal supervision.

Signed J. Allen Davis

Licensed Embalmer No. 653

P. O. Address St. Louis

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.)

PHYSICIAN

Underline the cause to which death should be charged (changing to locally).

No. 2
4-13-50
5-17-50
1 M2150

USE BLACK INK—TYPE OR PRINT LEGIBLY