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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 6 1943

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22426

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 1512

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Clayton ~~Twp.~~
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
On arrival St. Louis Co. Hospital 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DEACESED:

(a) State Mo. (b) County St. Louis

(c) City or town Lemay
(If outside city or town limits, write "RURAL")

(d) Street No. 609 Lagro ave.
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME GEORGE ALBERT KRAFT

3. (b) If veteran, name war #2

3. (c) Social Security No. None

4. Sex Male

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 January (Month) 26 (Day) 1904 (Year)

8. AGE: Years 39 Months 5 Days 3 If less than one day ..... hr. ..... min.

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

10. Usual occupation Unemployed

11. Industry or business .....

MOTHER FATHER

12. Name Henry Kraft

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

14. Maiden name Eleonora Schwob

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

16. (a) Informant Elenor Kraft

(b) Address 609 Lagro ave. Lemay, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-7-43 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olive Cemetery

18. (a) Signature of funeral director C. Hoffmeister Undertaking Co.

(b) Address 7814 S. Broadway, St. Louis, Mo.

19. (a) JUL 2 1943 (Date received local registrar) (b) C. P. McFarron M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June 29 29 year 1943 hour 6:15 minute P M.

21. I hereby certify that I attended the deceased from ....., 19..., to ....., 19...
that I last saw h..... alive on ....., 19...
and that death occurred on the date and hour stated above.

Immediate cause of death Natural causes.	Duration
Due to Coronary occlusion.	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy Yes.

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 Louis H. Boyd M.D.
Address Kirkwood, Mo. 6-30-43 Date signed .....

(Licensed Embalmer's Statement on Reverse Side)

JUL 16 1962

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 Linus C. Hoffmeister, Registered Apprentice No. ....., working under my personal supervision.

Signed Linus C. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadway

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.