

S. No. 2
 COM-2.43
 5-17-39
 X35697

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

28484

State File No. _____

ED AUG 30 1943

Registration District No. 756

Primary Registration District No. 2001

Registrar's No. 458

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

1. PLACE OF DEATH:
 (a) County Jasper
 (b) City or town Joplin
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Chaney Nursing Home 4
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution week
(Specify whether)
 In this community 27 years
years, months or days

3. (a) PRINT FULL NAME Frederick Max Kraus
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race W
 6. (a) Single, widowed, married. married
 6. (b) Name of husband or wife Emma L. Kraus 6. (c) Age of husband or wife if alive 72 years
 7. Birth date of deceased Nov 22 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
78 8 20 hr. _____ min

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

10. Usual occupation retired

11. Industry or business Luggage Shop

MOTHER FATHER { 12. Name Max Kraus
 { 13. Birthplace Hamburg Germany 4
(City, town, or county) (State or foreign country)
 { 14. Maiden name Lena Stromberg
 { 15. Birthplace Lancaster Penn 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Emma L. Kraus

(b) Address 320 Wall St

17. (a) removal (b) Date thereof 8-12-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Mo.

18. (a) Signature of funeral director Thornhill-Billon

(b) Address Joplin, Mo.

19. (a) 8-12-43 (b) Arthur Sushock
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jasper 49
 (c) City or town Joplin 5
(If outside city or town limits, write "RURAL")
 (d) Street No. 320 Wall St
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 11
 year 1943 hour 3 minute 30 P. M.

21. I hereby certify that I attended the deceased from Aug 11 to Aug 11 1943
 that I last saw him alive on Aug 11 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Left Side
Hemorrhagic
arterial sclerosis 433
 Other conditions _____
(Include pregnancy within 3 months of death)

Duration

Major findings:
 Of operations none 430
 Of autopsy _____

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? _____

While at work _____ Specify type of place _____
 Signature Michael J. ... Date signed 8/12/43
 Address _____

43 7 -681

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..... *David Wilson*

Licensed Embalmer No. *3898*

P. O. Address..... *J. J. Wilson, Wash*

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.