

FILED AUG 14 1944 8

1003

State File No.

Registration District No.

Registrar's No.

6815

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Missouri Baptist Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 12 hours  
(Specify whether  
In this community 11 years  
years, months or days)

3. (a) PRINT FULL NAME Mary Jane Kramer

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

4. Sex Female 5. Color or race White 6. (g) 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 June 7, 1933  
(Month) (Day) (Year)

8. AGE: Years 11 Months 1 Days 26 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Fred Henry Kramer  
13. Birthplace Red Bud Illinois  
(City, town, or county) (State or foreign country)  
14. Maiden name Florence Cremer  
15. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Fred Kramer  
(b) Address 6557 Scanlan Avenue  
17. (a) Burial (b) Date thereof Aug. 5, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation St. Trinity Cemetery

18. (a) Signature of funeral director Beiderwieden F. H. Inc  
(b) Address 1936 St. Louis Avenue

19. (a) AUG 4 1944 (b) J. F. Bredek  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 12  
(c) City or town St. Louis 93  
(If outside city or town limits, write "RURAL")  
(d) Street No. 6557 Scanlan Avenue  
(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 August day 2nd  
year 1944 hour 11 minute 20 A.M.

21. I hereby certify that I attended the deceased from Aug 1st 1944 to Aug 2nd 1944  
that I last saw her alive on Aug 2nd 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Streptococci Infection of left arm Duration 4 days

Due to \_\_\_\_\_  
Due to 107

Other condition Bronchial Pneumonia 1 day  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
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) (e) Means of injury 5  
23. Signature J. F. Bredek M.D. (M. D. or other) M.D.  
Address 3208 Franklin Ave Date signed 8-3-44

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

**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 St. Pauline

**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.**