

U.S. No. 2
FORM-5-43
Rev. 5-17-39
X365

FILED SEP 2 1944

Registration District No. 317 Primary Registration District No. 6076

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Normandy
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
7221 St. Andrews Rd.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether

In this community 7 days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Madison

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

(d) Street No. 1004 Neidringhaus Ave.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country L

3. (a) PRINT FULL NAME Ferdinand Kraus

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 5. Color or Race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Helen Kraus

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased October 6 1879
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>64</u>	<u>10</u>	<u>23</u>	_____ hr. _____ min.

9. Birthplace Unknown Austria 4
(City, town, or county) (State or foreign country)

10. Usual occupation Barber

11. Industry or business Own Business

12. Name Ferdinand Kraus

13. Birthplace Unknown Austria 4
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Oswald

15. Birthplace Unknown Austria 4
(City, town, or county) (State or foreign country)

16. (a) Informant Helen Kraus

(b) Address Granite City, Ill.

17. (a) Removal (b) Date thereof 8-31-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Edwardsville, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) AUG 31 1944 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 29
year 1944 hour 3:00 minute P. M.

21. I hereby certify that I attended the deceased from Aug 15
1944 to Aug 29 1944
that I last saw h. alive on Aug 29 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Strenuous

Due to Exhaustion of liver

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

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 [Signature] (M. D. or other) _____
Address 2812 N Grand Date signed 9-30-44

Duration 7 days

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

APR 5 1949

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.....

Albert E. Hoppa

Licensed Embalmer No..... *2971*

P.O. Address.....

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.