

**FILED JUN 19 1945**

**318**

Registration District No. \_\_\_\_\_

**1003**

Registrar's No. \_\_\_\_\_

**4964**

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:  
Enroute to City Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Cassie Mary Krafft

3. (b) If veteran, name war Nil  
3. (c) Social Security No. 494-10-0800

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

6. (b) Name of husband or wife August F. Krafft  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased About 1895  
(Month) (Day) (Year)

8. AGE: Years About 50 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Pants Machine Operator

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

12. Name Alex Mooneyham

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

14. Maiden name Mary Leona Gordon

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

16. (a) Informant Mrs. Dorothy Sommerich

(b) Address 4755a Maffitt Ave.

17. (a) Burial (b) Date thereof 6-6-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

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

(b) Address 4700 Washington Blvd.

19. (a) JUN 4 1945 (Date received local registrar)  
J. F. Braddock (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4607 Easton Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1  
year 1945 hour \_\_\_\_\_ minute 12 P. 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 Sudden thrombosis Duration \_\_\_\_\_  
Coronary self administered  
at the home 4607 Easton Ave. East  
State Antone Unknown.  
While suffering from temporary  
arterio-sclerosis

Other conditions (Include pregnancy within 3 months of death) 16392

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Suicide  
(b) Date of occurrence Unknown  
(c) Where did injury occur? At home  
(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)  
(c) Means of injury \_\_\_\_\_

Signature Albert H. Hoppe (M. D. or other)  
Address \_\_\_\_\_ Date signed 6/1/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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**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 *Robert S. Kafaric*

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.**