

**FILED** NOV 2 1945

STANDARD CERTIFICATE OF DEATH

State File No. **32076**

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3223**

1. PLACE OF DEATH:

(a) County **St. Louis**  
(b) City or town **St. Louis**  
(c) Name of hospital or institution **St. Luke's Hospital**  
(d) Length of stay: In hospital or institution **2 days**  
In this community **61 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**  
(c) City or town **St. Louis**  
(d) Street No. **3523 N. 11th. St.**  
(e) Citizen of foreign country? **0**

3. (a) PRINT FULL NAME

**Mr. William Kraus**

3. (b) If veteran, name war **none**

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 **December 7th. 1884**

8. AGE: Years **60** Months **10** Days **17** If less than one day hr. min.

9. Birthplace **St. Louis Mo.**

10. Usual occupation **Teamster**

11. Industry or business

12. Name **John Kraus**

13. Birthplace **Pa.**

14. Maiden name **Julia Mounbragh**

15. Birthplace **Pa.**

16. (a) Informant **Mr. Ben Kraus**

(b) Address **2604a N. 22nd. St.**

17. (a) **Burial** (b) Date thereof **10-27-45**

(c) Place: burial or cremation **Lake Charles Cem.**

18. (a) Signature of funeral director **Hy. Leidner U. Co.**

(b) Address **2223 St. Louis Ave.**

19. (a) **OCT 26 1945** (b) Registrar's signature **J. M. ...**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **24th** year **1945** hour **6:30 PM** minute **0** M.

21. I hereby certify that I attended the deceased from **Oct 22** to **Oct 24** 19**45**

that I last saw him alive on **Oct 24** 19**45** and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of prostate**

Due to **Cystitis**

Due to **51**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **Carcinoma of prostate**

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?  
(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

23. Signature **C. A. Watterberg M.D.** (M. D. or other)  
Address **3720 Washington** Date signed **10/26/45**

Duration **1 yr.**  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

**St Louis Mo**

**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 *John P. Buchholz*  
Licensed Embalmer No. *1674*  
P. O. Address *24413 St. Louis*

**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.**