. S. No. 2
00M—2-43
ev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED DEC 12 1945

Registration District No. 316 Primary Registration District No. 1003

State File No. 35508

Registrar's No. 10578

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: City Hospital 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether

In this community 63 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County 00 11

(c) City or town St. Louis (If outside city or town limits, write "RURAL") 2/17

(d) Street No. #5 North Ninth St. (If rural, give location) 9

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Louis Kraft

3. (b) If veteran, name war no

3. (c) Social Security No. 486-14-4873

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Kate Kraft

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased Dec. 28, 1881 (Month) (Day) (Year)

8. AGE: Years 63 Months 11 Days 5 If less than one day hr. min.

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

10. Usual occupation Elevator Operator

11. Industry or business York Hotel

FATHER
12. Name Fred Kraft
13. Birthplace France 5 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Elizabeth Skinner
15. Birthplace Pennsylvania (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Kate Kraft

(b) Address 3928 Potomac

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/45 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Joseph A. Howard

(b) Address 1619 S. Grand

19. (a) DEC 5 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 3 year 1945 hour 4 minute 30 a M.

21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Labor Premature

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Patrick S. E. Taylor (M. D. or other)

Address Dep. Cor. Date signed 12/5/45

(Licensed Embalmer's Statement on Reverse Side)

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. By W Wilkinson

Licensed Embalmer No. 3575

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.