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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

39054

State File No.

FILED JAN 13 1946

Registration District No. 1003 Primary Registration District No.

Registrar's No. 11509

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

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2mos-27 days (Specify whether
In this community Unk years, months or days)

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. 419 Cole St.,
(If rural, give location)
(e) Citizen of foreign country? Unknown (Yes or No)
If yes, name country

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3. (a) PRINT FULL NAME LOUIS CRAMER
3. (b) If veteran, name war ---
3. (c) Social Security No. ---
4. Sex male
5. Color or race white
6. (a) Single, widowed, married, divorced Unknown
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased January 29th, ?: (Month) (Day) (Year)

8. AGE: Years abt 77? Months Days If less than one day hr. min.

9. Birthplace Unknown (City, town, or county) 9 (State or foreign country)
10. Usual occupation Unknown
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)
16. (a) Informant M. Renard
(b) Address St. Louis City Hospital
17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof 12-26-4 (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address 3100 Rutger
19. (a) DEC 28 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 21st year 1945 hour 2:15 minute P M.
21. I hereby certify that I attended the deceased from 9/26/45, 19..., to 12/21/45, 19...; that I last saw him alive on 12/21/45, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death Empyema of Right Chest - non tuberculous — Duration 2mo.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations None
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature 1515 [illegible] 12/21/45
Address Date signed

(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.....

Licensed Embalmer No.....

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.