

FILED FEB 11 1946 STANDARD CERTIFICATE OF DEATH

State File No. **3570**
Registrar's No. **16**

Registration District No. **270**

Primary Registration District No. **5910**

1. PLACE OF DEATH:

(a) County **Remondette**
(b) City or town **Rural Remondette**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(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 **SAMUEL Joseph KRAMER**

3. (b) If veteran, name war **no** 3. (c) Social Security No. _____

4. Sex **MO** 5. Color or race **W** 6. (e) Single, widowed, married, divorced _____

6. (b) Name of husband or wife **Ethel Kramer** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **Nov 15 1877**
(Month) (Day) (Year)

8. AGE: Years **68** Months **2** Days **12** If less than one day hr. min.

9. Birthplace **Dashpen Ind. 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **Salesman**

11. Industry or business **Mens Wear**

12. Name **Ignatz Kramer**

13. Birthplace **Hungary 4**
(City, town, or county) (State or foreign country)

14. Maiden name **Paulina Meyers**

15. Birthplace **Germany**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Ethel Kramer**

(b) Address **Osceola Ark**

17. (a) **Burial** (b) Date thereof **1 27 46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **National Memorial**

18. (a) Signature of funeral director **National Memorial**

(b) Address **Memphis Tenn 29 Hayes**

19. (a) **2-5-46** (b) **James B. Welke**
(Date received local registrar's) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Ark** (b) County **Miss. 999**
(c) City or town **Osceola Ark 3**
(If outside city or town limits, write "RURAL")
(d) Street No. **220 N. Elizabeth 6**
(If rural, give location)
(e) Citizen of foreign country? **No 2** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **27**
year **1946** hour **4** minute **28 P.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 **Heart Attack According to History given by Family**

Due to _____

Due to _____

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

Major findings: Of operations **950**

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 **James Kelly coron** (M.D. or other)

Address **Hayes 2nd** Date signed **1-27-46**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1-46-19

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.