

FILED MAR 18 1946
318

1003

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Little Sisters of Poor 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 yrs.
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3225 N. Florissant Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Josephine Kram

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

4. Sex F! 5. Color or race W. 6. (a) Single, widowed, married, divorced S.

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

7. Birth date of deceased March 19, 1870
(Month) (Day) (Year)

8. AGE: Years 75 Months 11 Days 15 If less than one day hr. _____ min. _____

9. Birthplace Germany 4
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business _____

12. Name Karl Kram

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

14. Maiden name Mary Kram

15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Sister Jeane

(b) Address 3225 N. Florissant Ave.

17. (a) Burial (b) Date thereof 3-8-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Salvatory

18. (a) Signature of funeral director Arthur J. Connelly
(b) Address 3840 Lindell Blvd.

19. (a) MAR 7 1946 (b) Signature of Registrar J. F. Braddock
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 7th., 1946
year 1946 hour 5 minute 30 a. M.

21. I hereby certify that I attended the deceased from February 6, 1946 to March 7, 1946
that I last saw her alive on March 6, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: None
Of operations _____

Of autopsy None

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) None
(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 work)

23. Signature of Physician Bernard J. Wolf (M. D. or other) _____
Address 2307 Salvatory Date signed 3-7-46

Duration ???
PHYSICIAN
Underline the cause to which death should be charged statistically.

10248
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 W. H. Van Matre
Licensed Embalmer No. 2895
P. O. Address 4340 Lafayette

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.