

S. No. 2
M-5-43
7-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21920

State File No. _____

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4975**

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: Desloge Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5-days
(Specify whether
In this community 2-years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County 0-00
(c) City or town St. Louis 1817
(If outside city or town limits, write "RURAL")
(d) Street No. 4029 McPherson Ave.
(If rural, give location) 9
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Catherine I. Kramer
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 M.
6. (b) Name of husband or wife James Kramer 6. (c) Age of husband or wife if alive 36 years
7. Birth date of deceased Jan. 16th., 1906
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH; Month June day 1st., year 1946 hour 4 minute P. M.
21. I hereby certify that I attended the deceased from 26th day of May, 1946, to 1st day June, 1946, that I last saw h. or w. alive on June 1, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary embolism Duration 1 day
Due to auricular fibrillation 5 days
Due to Chronic myocarditis from arterial hypertension 3-4 years
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____

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

8. AGE: Years Months Days If less than one day
40 4 16 hr. _____ min.
9. Birthplace Iowa (City, town, or county) (State or foreign country)
10. Usual occupation At Home
11. Industry or business _____
12. Name Robert Wood
13. Birthplace Iowa (City, town, or county) (State or foreign country)
14. Maiden name Mary Maycoch UNKNOWN
15. Birthplace 9 (City, town, or county) (State or foreign country)
16. (a) Informant Mr. James Kramer
(b) Address 4029 McPherson Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-46
(Month) (Day) (Year)
(c) Place: burial or cremation Calvary
18. (a) Signature of funeral director Arthur J. Kennell
(b) Address 3840 Lindell Blvd.
JUN 3 1946 (Date received local registrar) (Registrar's signature)
19. (a) _____

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 Edward P. Rehms (M. D. or other) 9
Address 462 No. Taylor St. Louis Mo. Date signed 2 June 46

(Licensed Embalmer's Statement on Reverse Side)

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

D
d. F. Ren
Room 310, 462 N. Taylor
10 am.

APR 15 1947

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 Stanley Marshall
Licensed Embalmer No. 2868
P. O. Address 3845 Lindell

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.