S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7929

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 499

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town ~~St. Louis~~ Lemay
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Lemay Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days (Specify whether years, months or days) In this community Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County [redacted]
(c) City or town St. Louis, Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 3242 Delor,
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Louise Krafft
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Ferdinand
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Oct (Month) 9 (Day) 1870 (Year)
8. AGE: Years 76 Months 4 Days 24 If less than one day _____ hr. _____ min.
9. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Housewife
11. Industry or business _____
FATHER 12. Name Phillip Suessdorf
13. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
MOTHER 14. Maiden name Unknown
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)
16. (a) Informant Ferdinand O. Krafft,
(b) Address 3242 Delor
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/5/47 (Month) (Day) (Year)
(c) Place: burial or cremation Old Picker Cemetery
18. (a) Signature of funeral director Oscar J. Heffmeister
(b) Address 4016 Chippewa
19. (a) 3-7-47 (Date received local registrar) (b) Rick J. Allen M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 2 year 1947 hour 6 minute 30 A.M.
21. I hereby certify that I attended the deceased from Dec 10, 1945, to March 2, 1947 that I last saw her alive on March 1, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic myocarditis	1 yr 2 Mo
Due to: Chronic Nephritis	1 yr 2 Mo
Due to: Hypertension	1 yr 2 Mo
Other conditions (Include pregnancy within 3 months of death): None	
Major findings: Of operations: None	
Of autopsy: None	

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 Harry L. Yeckenich (M. D. ~~or other~~)
Address 3750 Gravois Date signed 3-4-47

(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 Ernest W. Spillers

Licensed Embalmer No. 4080

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.