No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 23 1948

Registration District No.

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 32697

Registrar's No. 8487

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis,
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution De Paul Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 21 Days (Specify whether years, months or days)

In this community

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. 516 E. Prairie Ave.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Kenneth Kraft

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 Single

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug. 15th, 1947
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
		21	hr. min.

9. Birthplace St. Louis
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Kenneth Kraft
13. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Doris Smith
15. Birthplace St. Louis, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Kenneth Kraft.
(b) Address 516 E. Prairie Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 8th, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Friedens Cem.

18. (a) Signature of funeral director Leidner Und. Co.
(b) Address 2223 St. Louis Ave.

19. (a) SEP 8 1947 (Date received local registrar) (b) J. H. Bredel (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 6 year 1947 hour 1:45 PM minute M.

21. I hereby certify that I attended the deceased from 8-28, 1947, to Sept 6, 1947, 19..; that I last saw him alive on 9-6, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Respiratory failure	
Due to uremia	
Due to dehydration prostration	
Other conditions none known (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause of 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 J. H. Thomas, M.D. (M. D. or other)

Address 2415 Kingshighway Date signed 9-8-47

De Paul Hospital

Jefferson City Printing Co.

(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 John P. Buckholz

Licensed Embalmer No. 1674

P. O. Address 2223 St. Louis Ave

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.