

No. 2
-5-43
5-17-39
X36671

FILED JAN 27 1948/49

Registration District No. _____

Primary Registration District No. 1001

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 days
(Specify whether
In this community 50 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson **48**
(c) City or town Kansas City **7**
(If outside city or town limits, write "RURAL")
(d) Street No. 4216 Cypress **8**
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Kraft

3. (b) If veteran, name war no
3. (c) Social Security No. none

4. Sex Male 5. Color or race white
6. (a) Single, widowed, married, divorced Divorced

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

7. Birth date of deceased June 6-1876
(Month) (Day) (Year)

8. AGE: Years 71 Months 7 Days 6
If less than one day hr. _____ min. _____

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

10. Usual occupation Cement finisher
Retired

11. Industry or business _____

12. Name William Kraft **4**

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

14. Maiden name Caroline

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

16. (a) Informant C. J. Kraft

(b) Address 2926 Waverly - Kas. City Kas

17. (a) Rural (b) Date thereof Jan 17-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Woodlawn Mem. Kas. C. Kas.

18. (a) Signature of funeral director Mrs. C. R. Foster

(b) Address 918 Brooklyn K.C. Mo.

19. (a) 1-14-48 (b) Sheraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 12
year 1948 hour 11 minute 45 A.M.

21. I hereby certify that I attended the deceased from Dec. 20, 1947 to Jan. 12, 1948
that I last saw him alive on Jan. 12, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Acute heart failure

Due to Cor pulmonale

Due to Chronic emphysema and and fibrosis

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

Major findings: _____
Of operations: _____ **93, D**

Of autopsy: See above

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 _____ **0**

23. Signature Wm W. Hart (M. D. or other) **MD**
Address Med. Dir. Gen'l Hosp. Date signed 1-13-48

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Dr. A. L. H. 0



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 *Robert A. Ferriman*

Licensed Embalmer No. *3700*

P. O. Address *918 Brooklyn*

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.