

FILED DEC 10 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37358

4939

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN KANSAS CITY		c. CITY (If outside corporate limits, write RURAL and give township) KANSAS CITY	
c. LENGTH OF STAY (in this place) 60 years		d. STREET ADDRESS (If rural, give location) 5331 Highland	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5331 Highland Little Sisters of the Poor			

3. NAME OF DECEASED (Type or Print) KATHRYN M. KRAFT		4. DATE OF DEATH (Month) (Day) (Year) NOV. 17, 1949	
a. (First)		c. (Last)	

5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH April 16, 1864	9. AGE (In years last birthday) 85	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) IOWA	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME CHARLES SCHROEDER	13b. MOTHER'S MAIDEN NAME MARGARET SCHMIDT	14. NAME OF HUSBAND OR WIFE CHARLES E.
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS CHARLES E. KRAFT, JR., 2208 East 59th
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18. NO OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) Chronic Myocarditis years		
	DUE TO (c) Chronic Nephritis		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Oct 8, 1949 to Nov 17, 1949 that I last saw the deceased alive on Nov 17, 1949, and that death occurred at 11:20 p.m., from the causes and on the date stated above.

23a. SIGNATURE John T. Skinner (Degree or title)	23b. ADDRESS 1402 Beacon Bldg.	23c. DATE SIGNED 11/19/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/21/49	24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	24d. LOCATION (City, town, or county) (State) KANSAS CITY, MISSOURI
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DATE REC'D BY LOCAL REG. 11-21-49	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 20 WEST LINWOOD BLVD., KANSAS CITY, MO.
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

....., Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Forrest W. Caldwell*.....

Licensed Embalmer No. *4714*.....

P. O. Address *K.C. Mo.*.....

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.