

FILED DEC 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43269
State File No. 04706
Registrar's No.

REG. DIST. NO. 317

PRIMARY REG. DIST. NO. 6076

96002
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Lemay Mo.		c. LENGTH OF STAY (in this place) 15	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lemay Nursing Home		e. STREET ADDRESS (If rural, give location) 4520 Tennessee	
3. NAME OF DECEASED (Type or Print) a. (First) Charlotte		b. (Middle)	
c. (Last) Kramer		4. DATE OF DEATH (Month) (Day) (Year) Dec. 16 1949	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 20 1889
9. AGE (in years last birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	
11. BIRTHPLACE (State or foreign country) St. Louis County D		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Jos. Brady		13b. MOTHER'S MAIDEN NAME Mina Pfitzinger	
14. NAME OF HUSBAND OR WIFE Fred Kramer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Fred Kramer 4520 Tennessee	
18. CAUSE 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchiogenic Carcinoma INTERVAL BETWEEN ONSET AND DEATH Unknown ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 11/27	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		162 X 2	
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)		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?	
22. I hereby certify that I attended the deceased from <u>2 Sept 1949</u> , to <u>16 Dec 1949</u> , that I last saw the deceased alive on <u>14 Dec 1949</u> , and that death occurred at <u>6:30 A.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) W.S. Mullerky, M.D.		23b. ADDRESS 3804 W. Wainwright	
23c. DATE SIGNED 16 Dec 1949		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 12-19-49		24c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis County		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Schumacher 3013 Meramec St.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE DEC 17 1949		26. (Licensed Embalmer's Statement on Reverse Side)	

FN Mullarty 1-5 PM
3804 Wilmington HU 7224

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 _____

working under my personal supervision.

Student Embalmer No.

Signed *Francis Williamson*

Signed.....
Student Embalmer *553*

Licensed Embalmer No. *3565*

P. O. Address *St Louis 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.