

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21715

FILED JUN 17 1950

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State File No.

Registrar's No. 5000

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. 5000	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) <u>ST. LOUIS</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>ST. LOUIS</u>		2129	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4904 MARYLAND AVE</u>				d. STREET ADDRESS (If rural, give location) <u>4904 MARYLAND</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u>		b. (Middle) _____		c. (Last) <u>KRAEMER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 6, 1950</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>OCT 8, 1862</u>	9. AGE (In years last birthday) <u>87</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>A.T. HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>GLUTH, DENMARK</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>NOT KNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>WILLIAM</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Anne Schmitz</u> ADDRESS <u>1521 N 17th</u>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hyperkalemia</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>2 yrs.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>H/3X</u>			
22. I hereby certify that I attended the deceased from <u>Sept 7, 1949</u> , to <u>June 6, 1950</u> , that I last saw the deceased alive on <u>June 6, 1950</u> , and that death occurred at <u>9 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Richard P. Day M.D.</u> (Degree or title)				23b. ADDRESS <u>3720 Washington</u>		23c. DATE SIGNED <u>6-6-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>June 9, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>VALHALLA CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY Mo.</u>	
DATE REC'D BY LOCAL REG. <u>JUN 7 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>A. Mow Gill</u> ADDRESS <u>2707 W. Grand</u>			

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

Stanley A. Dixon

Licensed Embalmer No. *4193*

P. O. Address *St. Louis*

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.