

U.S. No. 300 Rev. 10-48

FILED JUL 28 1950

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

State File No. 25468

4000

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

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 263 Registrar's No. 1722

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY OR TOWN Clayton		c. CITY OR TOWN Lemay	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 350 Orient ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis County Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) Nellie b. (Middle) ----- c. (Last) Kramer		4. DATE OF DEATH (Month) (Day) (Year) July 15 1950	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH February 15, 1870
9. AGE (in years last birthday) 80		IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) EUREKA, MISSOURI
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME UNKNOWN		13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE Benjamin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Anna Paschke 9713 S. Broadway	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction ANTECEDENT CAUSES None Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. None DUE TO (b) None DUE TO (c) None II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None	
INTERVAL BETWEEN ONSET AND DEATH 2 year		3 year	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 443X	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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?	
22. I hereby certify that I attended the deceased from Jan 10, 1947 , to July 15, 1950 , that I last saw the deceased alive on _____, 19____, and that death occurred at 1.15 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE Reuben D. Smith, M.D.		23b. ADDRESS 4145 So. Grand	23c. DATE SIGNED 7-15-50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 18, 1950	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	24d. LOCATION (City, town, or county) (State) 1200 Lemay Ferry Road
DATE REC'D BY LOCAL REG. 7-17-50	REGISTRAR'S SIGNATURE Robert L. Blum	25. FUNERAL DIRECTOR'S SIGNATURE C. Hoffmeister U.S. L. 66. 7814 S. Broadway	

*Dr. Pauline Smith
4145 S. Broadway*

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 *Harry R. Schumacher*

Licensed Embalmer No. *2679*

P. O. Address *2814 S. Broadway*

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.