

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43105

FILED JAN 16 1952

1003 State File No. 11530
Registrar's No. 11550

REG. DIST. NO. 318 PRIMARY REG. DIST. NO.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital		d. STREET ADDRESS 5400 Arsenal	

3. NAME OF DECEASED (Type or Print) FLORENCE KRAMER			4. DATE OF DEATH (Month) (Day) (Year) DECEMBER 26, 1951		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Dec 5 1897	9. AGE (In years last birthday) 54	10. KIND OF BUSINESS OR INDUSTRY
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) O Fallon Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Henry Kramer	13b. MOTHER'S MAIDEN NAME Dorothy Yahn	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Edith Bauer 3835 Mace

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1 month
ANTECEDENT CAUSES	DUE TO (b) Pulmonary Thc (right upper lobe)		
11. OTHER SIGNIFICANT CONDITIONS. Conditions contributing to the death but not related to the disease or condition causing death.	DUE TO (c)		

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? PO 2X

22. I hereby certify that I attended the deceased from **May 1, 1945**, to **Dec 26, 1951**, that I last saw the deceased alive on **Dec 25, 1951**, and that death occurred at **1:25 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John Schlenker, M.D.	23b. ADDRESS 5400 Arsenal Street	23c. DATE SIGNED 12-27-51
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 12-29-51	24c. NAME OF CEMETERY OR CREMATORY CALVARY
24d. LOCATION (City, town, or county) (State) St. Louis MO		

DATE RECD. BY LOCAL REGISTRY DEC 2 1951	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Culpen-Kelly 4386 Lindell
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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

James A. Lammers

Licensed Embalmer No. 4142

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.