

FILED MAY 19 1952

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

18212
 State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2962**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2239	
d. FULL NAME OF HOSPITAL OR INSTITUTION CITY HOSPITAL		d. STREET ADDRESS (If rural, give location) 23 822 GEYER	

3. NAME OF DECEASED (Type or Print) a. (First) CLARENCE b. (Middle) E. c. (Last) KRAMER			4. DATE OF DEATH (Month) (Day) (Year) 3-28-1952		
--	--	--	--	--	--

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH JAN. 28 1890	9. AGE (In years last birthday) 62	10. IF UNDER 1 YEAR Months	11. IF UNDER 1 YEAR Days	12. IF UNDER 1 YEAR Hours	13. IF UNDER 1 YEAR Min.
--------------------	-------------------------------	---	--------------------------------------	---	----------------------------	--------------------------	---------------------------	--------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALES MAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS Mo.		12. CITIZEN OF WHAT COUNTRY?	
---	--	-----------------------------------	--	--	--	------------------------------	--

13a. FATHER'S NAME JOSEPH KRAMER		13b. MOTHER'S MAIDEN NAME KATHERINE CHRISTY		14. NAME OF HUSBAND OR WIFE TILLIE C. 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. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS TILLIE C. KRAMER 8VV GEYER			
--	--	--	--	--	--	--	--

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Trachea ANTECEDENT CAUSES Mortid 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. Chc arthritic deformans 20 yrs						INTERVAL BETWEEN ONSET AND DEATH 3 mos	
---	--	---	--	--	--	--	--	--	--

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY YES <input checked="" 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) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 162X	
--	--	--	--	---	--

22. I hereby certify that I attended the deceased from **2/4 1952** to **3/18 1952**, that I last saw the deceased alive on **3/18 1952**, and that death occurred at **11:00 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE I. Belindewolf MD (Degree or title)		23b. ADDRESS 2026 S. 9th St. City		23c. DATE SIGNED	
--	--	---	--	------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE MAR. 31 1952		24c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY		24d. LOCATION (City, town, or county) (State) JEFFERSON BARRACKS Mo.	
---	--	----------------------------------	--	--	--	--	--

DATE REC'D BY LOCAL REG. 3-30-52		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas Ruetz 2906 Leavis			
--	--	---	--	---	--	--	--

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

Samuel E. Hill

Licensed Embalmer No. *43479*

P. O. Address *2906 Harris*

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.