

FILED JAN 20 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

5930 State File No. 2513

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 14

800  
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Highersville, Mo.</u>		c. LENGTH OF STAY (In this place)	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Highersville Mo.</u>		d. STREET ADDRESS (If rural, give location) <u>Rural</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Highersville RFD</u>		3. NAME OF DECEASED a. (First) <u>Bertha</u> b. (Middle) <u>A.</u> c. (Last) <u>Kraft</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 11, 1953</u>		5. SEX <u>Female</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>Feb. 11, 1870</u>		9. AGE (In years last birthday) <u>82</u> If under 1 year: Months <u>11</u> Days <u>0</u> If under 1 mo. Hours <u></u> Mins. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) <u>Exonia, Wis.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Wm. J. Meintz</u>		13b. MOTHER'S MAIDEN NAME <u>Wilhelmina Wolf</u>	
14. NAME OF HUSBAND OR WIFE <u>William F. Kraft</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mabel Kraft, 1104 W. 3</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>Myocarditis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4221	
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 about <u>about</u> , 19 <u>50</u> , to <u>Jan 11, 1953</u> , that I last saw the deceased alive on <u>Jan 5, 1953</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>A. L. Walter</u> (Degree or title) <u>MD</u>		23b. ADDRESS <u>Sedalia Mo</u>	
23c. DATE SIGNED <u>1-13-53</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>1-13-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	
24d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>M. Laughlin Broo - 519 S. Ohio</u>	
DATE REC'D BY LOCAL REG. <u>1-13-53</u>		REGISTRAR'S SIGNATURE <u>R. G. Campbell</u> Deputy	

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**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 \_\_\_\_\_

*J P M L Kary*

Licensed Embalmer No. 3153

P. O. Address Delaware 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.