

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19593

State File No. ....

5172

FILED JUN 4 1953  
BIRTH NO. .... REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. ....

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Firmin DeLoge Hosp</b>			e. STREET ADDRESS (If rural, give location) <b>2179 2907 Sidney St.</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Dorothy</b> b. (Middle) <b>F.</b> c. (Last) <b>Kraus</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>May 22 1953</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 19, 1915</b>	9. AGE (In years last birthday) <b>38</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At. Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis Mo.</b>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <b>Henry Sonntag</b>		13b. MOTHER'S MAIDEN NAME <b>Francis Telgmann</b>		14. NAME OF HUSBAND OR WIFE <b>Leo F. Kraus</b>		
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.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Leo F. Kraus 2907 Sidney St.</b>			
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) <b>Brain Tumor L. Frontal lobe</b> ANTECEDENT CAUSES Morbid 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.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>Infiltrating Tumor of Brain + Edema</b>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>none</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR? <b>237X</b>	
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"/>					
22. I hereby certify that I attended the deceased from <b>5 - 22 1953</b> to <b>5 - 22 1953</b> , that I last saw the deceased alive on _____, 19____, and that death occurred at <b>4:30 A m.</b> , from the causes and on the date stated above.						
23a. SIGNATURE (Degree or title) <b>Frank A. Palazzo MD</b>		23b. ADDRESS <b>4161 Lindell Blvd.</b>		23c. DATE SIGNED <b>5-22-53</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>May 25/53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis co. Mo.</b>			
DATE REC'D BY LOCAL REG. <b>MAY 22 1953</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Gebken Sons</b>		ADDRESS <b>2630 Gravois</b>		

(Licensed Embalmer's Statement on Reverse Side)

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

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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.....  
Signature of Student Embalmer

Signed... *Robert F. Gebken* .....

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If  
to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.