

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20818

State File No.

No. 300
10. 46

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>4604</u>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>Missouri Baptist</u>				e. STREET ADDRESS (If rural, give location) <u>3627 Folsom</u> <u>2178</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Max</u>		b. (Middle) <u>W</u>		c. (Last) <u>Kraft</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 22 1954</u>	
5. SEX Male <input type="radio"/> Female <input checked="" type="radio"/>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>July 16 1880</u>	
9. AGE (In years last birthday) <u>73</u>		10. USUAL OCCUPATION (Give kind of work demanding most of working life, even if retired) <u>Lineman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept Fire & Police</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>San Antonio Texas</u>	
12. CITIZEN OF WHAT COUNTRY? _____				13a. FATHER'S NAME <u>John Kraft</u>			
13b. MOTHER'S MAIDEN NAME <u>Jennie Oldenburg</u>				14. NAME OF HUSBAND OR WIFE <u>Josephine Kraft</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Josephine Kraft 3627 Folsom</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertrophy of Prostate</u> 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. <u>Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>1 year</u>	
19a. DATE OF OPERATION <u>May 21/54</u>		19b. MAJOR FINDINGS OF OPERATION <u>Transurethral Prostatic Resection - Hypertrophy Prostate</u>				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) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>610X</u>					
22. I hereby certify that I attended the deceased from <u>May 11, 1954</u> to <u>May 22, 1954</u> , that I last saw the deceased alive on <u>May 22, 1954</u> , and that death occurred at <u>12:30 P.</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Joseph E. Glenn M.D.</u>				23b. ADDRESS <u>958 Arcade Bldg</u>		23c. DATE SIGNED <u>5/24/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		24b. DATE <u>May 25 54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Missouri Crematory</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>	
DATE REC'D BY LOCAL REG. <u>MAY 24 1954</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Schnur</u> ADDRESS <u>3125 Lafayette</u>			

(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed..... *Joseph B. Hollman*

Licensed Embalmer No. *41014*

P. O. Address *3125 Palmyra*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.