

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31378

State File No.

10-300
10-48

FILED OCT 11 1954

BIRTH NO. _____		REG. DIST. NO. <u>224</u>		PRIMARY REG. DIST. NO. <u>3052</u>		Registrar's No. <u>354</u>			
1. PLACE OF DEATH a. COUNTY <u>Pettis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>		c. LENGTH OF STAY (in this place) <u>9 mo.</u>		c. CITY OR TOWN <u>Sedalia</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>Bothwell Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>712 W. 5th</u> 080%					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Joseph</u> b. (Middle) <u>Bertram</u> c. (Last) <u>Kraus</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 8 1954</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>Feb. 8 - 1868</u>			
9. AGE (in years last birthday) <u>86</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dry Goods</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Pilot Grove Mo</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Joseph B. Kraus</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Remspeal</u>		14. NAME OF HUSBAND OR WIFE <u>Mary Kraus</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (See no. or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Miss Philomene Kraus</u>		ADDRESS <u>Sedalia</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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis.</u> <u>6 mos.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8</u>	
				ANTECEDENT CAUSES DUE TO (b) <u>Senility.</u> <u>Over 5 years</u>					
				DUE TO (c) <u>Chronic Prostatitis.</u> <u>Over 5 yrs</u>					
				II. OTHER SIGNIFICANT CONDITIONS <u>None.</u>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Medical only.</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None.</u>		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) <u>None.</u>		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 <u>Over 5 yrs.</u> to <u>October 8th, 1954</u> , that I last saw the deceased alive on <u>Oct. 8th</u> , 19 <u>54</u> , and that death occurred at <u>9:45 A.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Jno. B. Carlisle, M.D.</u>				23b. ADDRESS <u>Sedalia, Missouri.</u>		23c. DATE SIGNED <u>Oct. 9th, 1954</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10-11-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		24d. LOCATION (City, town, or county) (State) <u>Sedalia Mo</u>			
DATE REC'D BY LOCAL REG. <u>10-9-54</u>		REGISTRAR'S SIGNATURE <u>Lovina Coont Sparty</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>McLaughlin Bros</u>		ADDRESS <u>Sedalia</u>			

Decided 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..... *K.P.M. Leary*

Licensed Embalmer No..... *B1*

P. O. Address..... *Sedale*

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.