

FILED MAR 7 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6283
Registrar's No. 1502

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY 2169	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place)		e. STREET ADDRESS (If rural, give location) 16 3834a Wyoming St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital			

3. NAME OF DECEASED (Type or Print) JOSEPH KRACKE			4. DATE OF DEATH Month (Day) (Year) Feb. 15 1955		
5. SEX Male <input checked="" type="checkbox"/>	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 10, 1886		9. AGE (In years last birthday) 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public Accountant		10b. KIND OF BUSINESS OR INDUSTRY -Self Employed		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo. <input checked="" type="checkbox"/>	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME John H. Kracke		13b. MOTHER'S MAIDEN NAME Anna Schotten		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Julia K. Kracke	
				ADDRESS 3834a Wyoming St.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 mos	
i. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Hypertension Heart Disease		ANTECEDENT CAUSES			
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) Hypertension - essential			
		DUE TO (c) Benign Atherosclerosis			
		ii. OTHER SIGNIFICANT CONDITIONS Pulmonary edema.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 443X	

22. I hereby certify that I attended the deceased from Jan 1954, to Feb 14, 1955, that I last saw the deceased alive on Feb 14, 1955, and that death occurred at 4:30A m., from the causes and on the date stated above.

23a. SIGNATURE Charles B. Oberwager		(Degree or title) M.D.		23b. ADDRESS 3103 Arsenal St.	
23c. DATE SIGNED 2/16/55					
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Feb. 17, 1955		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
				24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	

DATE REC'D BY LOCAL REG. FEB 16 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser	
				ADDRESS 4228 S. Kingshighway Bl.	

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 *Edwin M. Burnett*.....

Licensed Embalmer No. *3029*

P. O. Address.....

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.