

FILED SEP 1 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27871

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6648

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Geitner Home		e. STREET ADDRESS (If rural, give location) 17 5204 Delor St. 2149	
3. NAME OF DECEASED (Type or Print) a. (First) Alma		b. (Middle)	c. (Last) Krapf
4. DATE OF DEATH July 31, 1955		5. SEX Female	
6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 27, 1883	9. AGE (In years last birthday) 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Henry Clacker		13b. MOTHER'S MAIDEN NAME Marie Schmidt	14. NAME OF HUSBAND OR WIFE Ferdinand (Deceased)
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 ADDRESS Ewald Krapf 5204 Delor	
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) Arterio-sclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio-sclerotic heart disease DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Cerebro-malacia Parkinsonism	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input 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?	
22. I hereby certify that I attended the deceased from Nov. 3, 1954, to July 31, 1955, that I last saw the deceased alive on July 29, 1955, and that death occurred at 5:10 P. M., from the causes and on the date stated above.			
23a. SIGNATURE J. J. Moskop, M.D.		23b. ADDRESS 3554 Victor St. St. L. 4 MO	23c. DATE SIGNED 8/1/55
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Aug. 3, 1955	24c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cem.	24d. LOCATION (City, town, or county) (State) St. Louis, County, Mo.
DATE REC'D BY LOCAL REG. AUG 1 1955		REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Schumacher 3013 Meramec St.

(Licensed Embalmer's Statement on Reverse Side)

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.....

Jack Haupt

Licensed Embalmer No. 477

P. O. Address *St. Louis*

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.