

FILED JUN 3 1957

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18940

State File No. \_\_\_\_\_

4872

|  |                               |   |   |  |   |   |   |
|--|-------------------------------|---|---|--|---|---|---|
| BIRTH NO. _____  |                               | REG. DIST. NO. <u>318</u>   |   | PRIMARY REG. DIST. NO. <u>1003</u>   |   | Registrar's No. _____   |   |
| 1. PLACE OF DEATH<br>a. COUNTY _____   |                               |   |   | 2. USUAL RESIDENCE (Where deceased lived). If institution: residence before admission!<br>a. STATE <u>Missouri</u> b. COUNTY _____ |   |   |   |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <u>ST. LOUIS Mo</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?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><u>01 3100<sup>a</sup> WYOMING 2/67</u>   |                               |   |   | e. STREET ADDRESS (If rural, give location)<br><u>3100<sup>a</sup> WYOMING</u>   |   |   |   |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>JOSEPH</u> b. (Middle) <u>KRAMER</u> c. (Last) _____  |                               |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>MAY 22 1957</u> |  |   |   |   |
| 5. SEX <u>0</u>  | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWER</u>   | 8. DATE OF BIRTH <u>MAR. 11 1865</u>                        |  | 9. AGE (In years last birthday) <u>92</u>     | 10. UNDER 1 YEAR Days _____   | 11. UNDER 12 HRS. Hours _____                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  |   | 11. BIRTHPLACE (City and State or Foreign Country) <u>AUSTRIA</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.-A.</u>  |   |
| 13a. FATHER'S NAME<br><u>JOSEPH KRAMER</u>   |                               |   | 13b. MOTHER'S MAIDEN NAME<br><u>UNKNOWN</u>                 |  | 14. NAME OF HUSBAND OR WIFE<br><u>UNKNOWN</u> |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____  |                               | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |   | 17. INFORMANT'S SIGNATURE OR NAME<br><u>MARIE JECKLIN</u> ADDRESS<br><u>3100<sup>a</sup> WYOMING</u>                               |   |   |   |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.  |                               | 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>acute Cardiac Collapse</u>  |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Full</u> |
|  |                               | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>arterio-sclerotic Heart Disease</u><br>DUE TO (c) <u>General arterio-sclerosis</u> |   |  |   |   |   |
|  |                               | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><u>Senility</u>  |   |  |   |   |   |
| 19a. DATE OF OPERATION _____   |                               | 19b. MAJOR FINDINGS OF OPERATION<br><u>420.0</u>  |   |  |   | 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) (m.) _____   |                               | 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>May</u> , 19 <u>56</u> , to <u>May 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 21</u> , 19 <u>57</u> , and that death occurred at <u>1:00 P</u> m., from the causes and on the date stated above. |                               |   |   |  |   |   |   |
| 23a. SIGNATURE<br><u>Dr. Carl Smith, M.D.</u>  |                               |   | 23b. ADDRESS<br><u>2621 S. Jefferson, St. L. Mo</u>         |  | 23c. DATE SIGNED<br><u>May 23/57</u>          |   |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>   |                               | 24b. DATE<br><u>MAY 24 1957</u>   |   | 24c. NAME OF CEMETERY OR CREMATORY<br><u>RESURRECTION CEM.</u>   |   | 24d. LOCATION (City, town, or county) (State)<br><u>ST. LOUIS Mo</u>  |   |
| DATE REC'D BY LOCAL REG.<br><u>MAY 24 '57</u>  |                               | REGISTRAR'S SIGNATURE<br><u>J. Carl Smith, M.D.</u>   |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>Thomas Kates 2906 Georgia</u> ADDRESS _____   |   |   |   |

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

4001

12-3585

**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.....  
*Leo J. Budd*

Licensed Embalmer No. *398*

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.