

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29665  
STATE FILE NUMBER

FILED AUG 26 1957

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7425

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, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. ANTHONY'S HOSPITAL 22</u>			Length of stay in 1b	d. STREET ADDRESS <u>4837 GERMANIA</u> (If outside, give location)	
3. NAME OF DECEASED (Type or print) First <u>"A"</u> Middle <u>"A"</u> Last <u>KRAUS</u>			4. DATE OF DEATH <u>AUG. 8 1957</u> Month Day Year		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 7 1957</u>	9. AGE (In years last birthday) <u>—</u>	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>5</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>RAYMOND KRAUS</u>			14. MOTHER'S MAIDEN NAME <u>EVELYN BASICH</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>RAYMOND KRAUS 4837 GERMANIA</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia &amp; marked prematurity (28 wks)</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>(Placenta previa &amp; SEVERE Hemorrhage)</u> DUE TO (c) <u>761.5</u>					INTERVAL BETWEEN ONSET AND DEATH <u>from Birth</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>		
20c. TIME OF INJURY. Hour <u>—</u> Month <u>—</u> Day <u>—</u> Year <u>—</u> a. m. <u>—</u> p. m. <u>—</u>					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <u>Birth 8/7/</u> to <u>8/8/57</u> and last saw <u>him</u> alive on <u>8/8/57</u> Death occurred at <u>3:00 am</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>W. J. Gava MD</u>			22b. ADDRESS <u>3808 Wilmington Ave</u>		22c. DATE SIGNED <u>8/8/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>AUG. 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>S. S. Peter &amp; Paul</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>	
24. FUNERAL DIRECTOR <u>Thomas Kuter 2906 Gravois</u>			25. DATE RECD. BY LOCAL REG. <u>AUG 8 '57</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>	

(Licensed Embalmer's Statement on Reverse Side)

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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

*Not Embalmed*

Signed *Thomas Cline* .....

Licensed Embalmer No. ....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.