

FILED OCT 21 1957

STATE FILE NUMBER
9488

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

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All 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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 3819 Virginia Ave.			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 01/6 3819 Virginia Ave.
3. NAME OF DECEASED (Type or print) First Middle Last Lena Kracke			4. DATE OF DEATH Month Day Year Oct. 10, 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1875	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Henry Kracke			14. MOTHER'S MAIDEN NAME Susan Beckelhaupt		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT Address Mrs. Anna Mekher - 3452 Dunnica		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Pulmonary tuberculosis Tuberculosis with fibroid ptosis and myocarditis & chr. interstitial nephritis and chr. myocarditis & chr. interstitial nephritis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Tuberculosis (fibroid ptosis) DUE TO (c) chr. myocarditis & chr. interstitial nephritis					INTERVAL BETWEEN ONSET AND DEATH 1948 1957
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) 1002x		
20c. TIME OF INJURY: Hour Month, Day, Year a. m. p. m.					
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.) 1948 to 1957	20f. CITY, TOWN, OR LOCATION St. Louis		COUNTY STATE
21. I attended the deceased from 1948 to 1957 and last saw her alive on 10-9-57 Death occurred at 01/10 - 1957 10:45 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE W. H. Walters M.D.		(Degree or title) W. H. Walters	22b. ADDRESS 3608 S. Grand		22c. DATE SIGNED Oct 10, 1957
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Oct. 14, 1957	23c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
24. FUNERAL DIRECTOR WACKER-HELDERLE-3634 Gravois Ave.		ADDRESS	25. DATE RECD. BY LOCAL REG. OCT 11 57	26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.	

STATEMENT BY LICENSED EMBALMER

(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 *Robert Wheeler*

Licensed Embalmer No. 21

P. O. Address *Ham*

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.