

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-007460  
STATE FILE NUMBER  
2333

FILED MAR 5 - 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		d. STREET ADDRESS (If outside, give location) 5400 Finkman Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR KRACHT		4. DATE OF DEATH Month Day Year Feb. 25 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President-Valley Bag Co.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
13a. FATHER'S NAME Unknown Kracht		13b. MOTHER'S MAIDEN NAME Emma Bick	14. NAME OF HUSBAND OR WIFE Adeline L. Kracht
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) (If yes, give year or dates of service) No None		16. SOCIAL SECURITY NO.	17. INFORMANT Address Adeline L. Kracht 5400 Finkman Ave.
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>Carcinoma - Generalized Abdominal Tumor?</u> DUE TO (b) <u>Metastatic from Bilious Cancer (probably)</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1561</u> 19. WAS AUTOPSY PERFORMED? 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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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 Dec 1957 to Feb 25 - 1958 and last saw him alive on Feb 25 - 1958 Death occurred at 7:10 A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Arnold S. Klein MD		22b. ADDRESS 2632 40 Kingshighway	22c. DATE SIGNED 2-26-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Mar. 1, 1958	23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery
24. FUNERAL DIRECTOR Kriegshauser		25. DATE RECD. BY LOCAL REG. FEB 26 58	26. REGISTRAR'S SIGNATURE Earl Smith MD
23d. LOCATION (City, town, or county) St. Louis Co. Mo.		23e. (State)	

(Licensed Embalmer's Statement on Reverse Side)

300  
-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 *William B. White* .....

Licensed Embalmer No. *4291* .....

P. O. Address *428 1/2 ...*

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.