

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-016930

STATE FILE NUMBER

FILED APR 23 1958

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 936

Health, Welfare, Public Service  
300  
1-56  
All diseases in Part I must be casually 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 <b>St Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St Louis</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Manchester</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY FOR TOWN <b>St Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Manchester Nursing Home</b>			Length of stay in lb <b>5-25-1957</b>		d. STREET ADDRESS (If outside, give location) <b>5605 Tholozan</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>L</b> Last <b>Kraut</b>				4. DATE OF DEATH Month <b>4-</b> Day <b>3</b> Year <b>1958</b>					
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-26-1865</b>		9. AGE (In years last birthday) <b>92</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Globe-Democrat</b>			11. BIRTHPLACE (City and state or country) <b>Anamosa, Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lewis Kraut</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>unk.</b>		17. INFORMANT <b>Kate Kraut</b> Address <b>5605 Tholozan St Louis, Mo</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Cerebral Emboli</b> DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>Arteriosclerosis 332X</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic bronchitis, Senility</b>								INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b> <b>Don't know</b> <b>Don't know</b>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Stroke</b>						
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____			20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. CITY, TOWN, OR LOCATION <b>Manchester</b>			20f. COUNTY <b>Mo.</b> STATE <b>Mo.</b>			
21. I attended the deceased from <b>Dec. 10, 57</b> to <b>Mar. 31, 58</b> and last saw her alive on <b>Mar. 31, 58</b> Death occurred at <b>4:00 A.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Ralph W. Zalley, M.D.</b>				22b. ADDRESS <b>Manchester 141</b>				22c. DATE SIGNED <b>4-3-58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-5-1958</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>St Louis County, Mo</b>		
24. FUNERAL DIRECTOR <b>Hoffmeister Colonial Mortuary</b> ADDRESS <b>6464 Chippewa Street St. Louis 9, Mo</b>				25. DATE RECD. BY LOCAL REG. <b>4-3-58</b>		26. REGISTRAR'S SIGNATURE <b>Herbert R. Donke M.D.</b>			

(Licensed Embalmer's Statement on Reverse Side)

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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

Signed *Eric C. Rainey*

Licensed Embalmer No...*4*

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.