

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030651

STATE FILE NUMBER

FILED AUG 28 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7741

S. 300
v. 1-57

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 6814 Marquette		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 4039 6814 Marquette		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Linda Sue Kralemann			4. DATE OF DEATH Month Day Year August 7, 1958		
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 Aug. 21, 1957	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 0 11 16 Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Edward Kralemann		13b. MOTHER'S MAIDEN NAME Bettie Kimbrell		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Edward Kralemann, 6814 Marquette		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Acute broncho-pneumonia, bilateral lower lobes, probably of aspirative nature with secondary acute septic splenitis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) 2. Left subdural hemorrhage, trauma probably suffered when deceased fell from mother's arms, in home DUE TO (c) on August 6, 1958 about 9:10 p.m. ACCIDENT					INTERVAL BETWEEN ONSET AND DEATH lobes, recent.
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? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) see above E902.0			
20c. TIME OF INJURY Hour Month, Day, Year 9:10 P.M. 8/6/58		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 3 home			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. CITY, TOWN, OR LOCATION St. Louis, Missouri		20f. COUNTY STATE 000 Missouri	
21. I attended the deceased from _____, to _____ and last saw her alive on _____ Death occurred at 1:15 P.M. _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Patrick S. Taylor Coroner 3			22b. ADDRESS 1300 Clark		22c. DATE SIGNED AUG 11 1958
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Aug. 11, 1958	23c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County Missouri
24. FUNERAL DIRECTOR ADDRESS WACKER-HELDERLE-3634 Gravois Ave.		25. DATE RECD. BY LOCAL REG. AUG 11 '58		26. REGISTRAR'S SIGNATURE Carl Smith MD	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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 *Delis J. Krupin*

Licensed Embalmer No. *3497*

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.