Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-015275
STATE FILE NUMBER

FILED MAY 8 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 3382

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis, Mo. — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis City Hos. #1 — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo
b. COUNTY St. Louis
c. CITY OR TOWN ~~ST. LOUIS, MO.~~ 4000 Pine Lawn — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) SHAMROCK NURSING HOME — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First WILLIAM Middle Last KRAUS
4. DATE OF DEATH Month Mar. Day 7, Year 1959
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ ?? DIVORCED ☐ Unknown
8. DATE OF BIRTH 9/23/71
9. AGE (In years ... hday) 87 — 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) UNKNOWN
10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN
11. BIRTHPLACE (City and state or country) ? Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME JOHN
13b. MOTHER'S MAIDEN NAME MARY STEINBE
14. NAME OF HUSBAND OR WIFE
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. ?
17. INFORMANT Address ST. LOUIS CITY HOSP. #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Accident
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____
DUE TO (c) _____ 331X
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
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 2/24/59, to 3/7/59 and last saw her X him alive on 3/7/59
Death occurred at 9:00 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] MD
22b. ADDRESS 1515 Lafayette Ave.
22c. DATE SIGNED 3/7/59

23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE 4-6-59
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis, Missouri

24. FUNERAL DIRECTOR Cullen & Kelly — ADDRESS 7267 Natural Bridge
25. DATE RECD. BY LOCAL REG. APR 6 '59
26. REGISTRAR'S SIGNATURE Carl Smith, M.D. M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Not Embalmed, Student Embalmer No. ..... working under my personal supervision.

Student ..... Signature of Student Embalmer

Signed James A. Lammers

Licensed Embalmer No. 4142

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.