

**RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**FILED VS AUG 3 1959**

**59-026857**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 6341**

<b>1. PLACE OF DEATH</b> a. COUNTY		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Saint Louis</b>		Length of stay in lb	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <b>8650 Delmar Blvd.</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>EDWARD</b> Middle <b>K</b> Last <b>KRAMER</b>			<b>4. DATE OF DEATH</b> Month <b>July</b> Day <b>4</b> Year <b>1959</b>
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>1/24/95</b>
<b>9. AGE</b> (last birthday) <b>64</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Realtor</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Real Estate</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Wisconsin</b>
<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>		<b>13a. FATHER'S NAME</b> <b>Bernard Kramer</b>	
<b>13b. MOTHER'S MAIDEN NAME</b> <b>Tillie Ethel Kevin</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>May H. Kramer</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes. W.W.#1</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unk.</b>	<b>17. INFORMANT</b> Address <b>Mrs. Mav H. Kramer-8650 Delmar Blvd.</b>
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronal artery thrombosis</b> DUE TO (b) <b>Atherosclerosis, old coronary thrombosis</b> DUE TO (c) <b>Previous C.V.A. left hemiplegia</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>3 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>332x</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) <b>332x</b>	
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	
<b>21. I attended the deceased from</b> <b>June 1949</b> to <b>July 4/59</b> and last saw <sup>her</sup> him alive on <b>7/4/59</b> Death occurred at <b>2:10 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
<b>22a. SIGNATURE</b> (Degree or title) <b>Alfred Feldman M.P.</b>		<b>22b. ADDRESS</b> <b>634 N. Ogden</b>	
<b>22c. DATE SIGNED</b> <b>7/5/59</b>		<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>	
<b>23b. DATE</b> <b>7/6/59</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Olive Cemetery</b>	
<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis County, Missouri</b>		<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Herman Rindskopf, Inc. 5216 Delmar</b>	
<b>25. DATE RECD. BY LOCAL REG.</b> <b>JUL 6 '59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Earl Smith, M.D.</b>	

DED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*m8B*

AUG 2 1959

SEP 3 1959

NOV 25 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Peter B. Dubrow

Licensed Embalmer No. 3691

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.