RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS NOV 17 1960 318 1003 –60–043814

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10725 STATE FILE NUMBER

DED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Alexian Bros. Hosp
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY
c. CITY OR TOWN: ST. Louis
Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 2801 S. BROADWAY
Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print): First: JOHN Middle: Last: KRAMER

4. DATE OF DEATH: Month: NOV Day: 4 Year: 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. Married ☑ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 8-17-1905

9. AGE (last birthday): 55

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TAVERN OPERATOR

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): AUSTRIA - HUNGARY

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: JOHN KRAMER

13b. MOTHER'S MAIDEN NAME: KATHERINE KOLB

14. NAME OF ~~HUSBAND~~ OR WIFE: CHRISTINA KRAMER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: CHRISTINA KRAMER Address: 2801 S. Broadway

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cirrhosis of the Liver — INTERVAL BETWEEN ONSET AND DEATH: 1yr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 581.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

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 0 1959, to death and last saw her/him alive on 4 Nov 1960

Death occurred at 7PM m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John G. Kellett M.D. John G. Kellett

22b. ADDRESS: 2623 Telegraph Road

22c. DATE SIGNED: 11-7-1960

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: Nov 7, 1960

23c. NAME OF CEMETERY OR CREMATORY: New St. MARCUS

23d. LOCATION (City, town, or county): ST. Louis (State): Mo.

24. FUNERAL DIRECTOR: Thomas Kutis ADDRESS: 2906 Broadway

25. DATE RECD. BY LOCAL REG.: 11-7-1960

26. REGISTRAR'S SIGNATURE: Paul Smith M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 434

P. O. Address 2906

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.