

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 2 0 1960

-60-045543

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 429

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>COLE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLARK</u>		Length of stay in 1b	c. CITY OR TOWN <u>Eugene</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>R 1</u> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ELIZA</u> Middle <u>ELLEN</u> Last <u>KRAFT</u>			4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>60</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-26-82</u>	9. AGE (last birthday) <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Hickory Hill Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>JOHN T. MUSICK</u>		13b. MOTHER'S MAIDEN NAME <u>MIRINDA SIMPSON</u>		14. NAME OF HUSBAND OR WIFE <u>A. J. KRAFT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Gladys Smith Webster Groues</u> Address <u>544 Summit</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest -</u> DUE TO (b) <u>Chr. myocarditis accompanied</u> DUE TO (c) <u>by cardiac asthma.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input 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.)			
20c. TIME OF INJURY Hour <u>10:30 p.m.</u> Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 <u>Dec 13 1960</u> to <u>Dec 13 1960</u> and last saw her <u>alive on Dec 13 1960</u> Death occurred at <u>10:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>E. O. Shelton M.D.</u> (Degree or title)		22b. ADDRESS <u>Eldon, Mo.</u>		22c. DATE SIGNED <u>Dec 14 1960</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-17-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LAKE CHARLES</u>		23d. LOCATION (City, town, or county) (State) <u>ST Louis Co Mo</u>	
24. FUNERAL DIRECTOR <u>Stephan Furniture Home</u> ADDRESS <u>Russellville Mo</u>		25. DATE RECD. BY LOCAL REG. <u>19 December 1960</u>		26. REGISTRAR'S SIGNATURE <u>R. P. ...</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS DEC 21 1960

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 *J. M. Steffensen*

Licensed Embalmer No. 2807

P. O. Address Russell

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