

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-035348

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2423 STATE FILE NUMBER

AMENDED

FILED SEP 19 1961

1. PLACE OF DEATH
 a. COUNTY St. Louis
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN _____ Length of stay in 1b 21 days
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gravois Rest Haven Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 3137A Osage Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year
William G Kraft 8 27 61
 5. SEX M 6. COLOR OR RACE W 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 9/14/1872 9. AGE (last birthday) 88
 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book Binder 10b. KIND OF BUSINESS OR INDUSTRY Sc 11. BIRTHPLACE (City and state or country) St. Louis Mo. 12. CITIZEN OF WHAT COUNTRY USA
 13a. FATHER'S NAME August 13b. MOTHER'S MAIDEN NAME Marie Siebenmann 14. NAME OF HUSBAND OR WIFE Wilhelmina
 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no 17. INFORMANT Address Wilhelmina Kraft 3137A Osage

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Cerebral Thrombosis INTERVAL BETWEEN ONSET AND DEATH 1 hr.
 DUE TO (b) Arterio Sclerotic Cardio Vascul Disease
 DUE TO (c) _____
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 422.1
 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 NONE
 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
 20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____

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.) 8-6-61 20f. CITY, TOWN, OR LOCATION St. Louis COUNTY _____ STATE _____
 21. I attended the deceased from 8-27-61 to 8-20-61 and last saw him/her alive on 8-20-61
 Death occurred at 7:40 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Allen McNeaney M.D. 22b. ADDRESS 4308 Eyer 22c. DATE SIGNED 8-29-61
 23a. BURIAL, CREMATION, REMOVAL (Specify) cremation 23b. DATE 8/30/61 23c. NAME OF CEMETERY OR CREMATORY Mo Crematory 23d. LOCATION (City, town, or county) (State) St. Louis Mo.
 24. FUNERAL DIRECTOR Schuma cher 3013 Meramec ADDRESS _____ 25. DATE RECD. BY LOCAL REG. 8-29-61 26. REGISTRAR'S SIGNATURE [Signature]

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

4308 Exeter
Shrewsbury
Mass 01545

County

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 Jack Haupt
Licensed Embalmer No. 4746
P. O. Address Shrewsbury

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.