

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046529

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **12382**

STATE FILE NUMBER

AMENDED

FILED JAN 11 1962

DATE AMENDED

INSTEAD OF

DOCUMENT

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN<br><b>St. Louis, Mo.</b>  |                                  | c. CITY OR TOWN<br><b>St. Louis</b>   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br><b>St. Anthonys Hospital</b>   |                                  | d. STREET ADDRESS (If outside, give location)<br><b>320 East Ripa.</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>SISTER MARY HERMAN KRAMER</b>   |                                  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>December 30, 1961</b> |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>                     | 8. DATE OF BIRTH<br><b>11-30-1910</b>                          |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Teacher</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (last birthday)<br><b>51</b>                            |
| 11. BIRTHPLACE (City and state or country)<br><b>St. Louis, Mo.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |  |
| 13a. FATHER'S NAME<br><b>Herman Kramer</b>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Olinger</b>   |  |
| 14. NAME OF HUSBAND OR WIFE  |                                  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |  |
| 16. SOCIAL SECURITY NO.  |                                  | 17. INFORMANT<br><b>Sister Kathleen</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Failure</b><br>DUE TO (b) <b>Chronic cardiac decompensation / Puro.</b><br>DUE TO (c) <b>Arterio-sclerotic heart disease</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>420.0</b> |                                  | 18. INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" 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.)   |                                  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.  |                                  | 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 <b>4-19-61</b> to <b>12-30-61</b> and last saw her alive on <b>12-30-61</b><br>Death occurred at <b>3</b> <b>A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.   |                                  | 22a. SIGNATURE (Degree title)<br><b>Ed Smith M.D.</b>   |  |
| 22b. ADDRESS<br><b>2623 Telegraph Rd.</b>  |                                  | 22c. DATE SIGNED<br><b>1-2-62</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>removal</b>  |                                  | 23b. DATE<br><b>1-2-1962</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Notre Dame Cemetery</b>   |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis Co., Mo.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Thomas Kutis</b>  |                                  | 25. DATE RECD. BY LOCAL REG.<br><b>JAN 1 1962</b>   |  |
| 26. ADDRESS<br><b>2906 Gravois Ave.</b>  |                                  | 26. REGISTRAR'S SIGNATURE<br><b>Ed Smith M.D.</b>   |  |

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

**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 James C. Hill

Licensed Embalmer No. 4347

P. O. Address 2906 Prairie

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.