

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-044498

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10825**

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. CITY OR TOWN <b>BRENT WOOD</b>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>24 NORTHCOTE DR.</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FANELLE KRAMER</b>			4. DATE OF DEATH Month Day Year <b>NOVEMBER 9 1962</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 06</b>
9. AGE (last birthday) <b>56</b>		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) <b>HOUSE MOTHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MONTICELLO</b>	11. BIRTHPLACE (City and state or country) <b>RUSSIA</b>
12. CITIZEN OF WHAT COUNTRY <b>USA.</b>		13a. FATHER'S NAME <b>LEON Neizer</b>	
13b. MOTHER'S MAIDEN NAME <b>—</b>		14. NAME OF HUSBAND OR WIFE <b>EDWARD L. KRAMER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>EDWARD L. KRAMER</b>		Address <b>124 NORTHCOTE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS, ETIOLOGY UNDETERMINED</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <b>332+</b>			
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 a.m. p.m. 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 <b>NOV. 2, 1962</b> to <b>NOV. 9, 1962</b> and last saw her/him alive on <b>NOV. 9, 1962</b> Death occurred at <b>6:20 P.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>C. D. Vermillion, M.D.</i>		22b. ADDRESS <b>BARNES HOSPITAL</b>	
22c. DATE SIGNED <b>11/10/62</b>		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	23b. DATE <b>Nov 10, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MISSOURI CREMATORY</b>	23d. LOCATION (City, town, or county) <b>ST. LOUIS Mo.</b>
24. FUNERAL DIRECTOR <b>Kutzi Funeral Home Inc. 2906 Harris</b>		25. DATE RECD. BY LOCAL REG. <b>Nov. 10, 1962</b>	26. REGISTRAR'S SIGNATURE <i>Roan Smith, M.D.</i>

STATE OF ILLINOIS  
DEPARTMENT OF HEALTH

**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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address 2906 Green

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.

*Not embalmed*

*Not*