

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-042333**

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3230

DO NOT WRITE ON THIS STUB

AMENDED

FILED OCT 30 1963

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MANCHESTER</u>		c. CITY OR TOWN <u>MEHLVILLE</u>	
Length of stay in 1b <u>10 DAYS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>MANCHESTER NUR. HOME</u>		d. STREET ADDRESS (If outside, give location) <u>5002 BUTLER HILL RD.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN HENRY KRAEMER</u>			4. DATE OF DEATH Month Day Year <u>OCT-19-1963</u>
5. SEX <u>MALE</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>9-31-1885</u>
9. AGE (last birthday) <u>78</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - FIREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GRAND PACKING Co.</u>	11. BIRTHPLACE (City and state or country) <u>ST LOUIS 6. Mo. U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>GEORGE KRAEMER</u>	
13b. MOTHER'S MAIDEN NAME <u>MARGARET KROUPA</u>		14. NAME OF HUSBAND OR WIFE <u>HOUSE KRAEMER</u> <span style="float: right;">DECEASED</span>	
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. <u>NIL</u>	
17. INFORMANT <u>LEO KRAEMER</u>		Address <u>5880 KERTH RD. ST LOUIS 09 Mo.</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>CEREBRAL HEMORRHAGE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>GENERAL ARTERIOSCLEROSIS</u>			<u>?</u>
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>CHRONIC GLOMERULONEPHRITIS</u>			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 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.)	
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 <u>OCT. 9, 1963</u> to <u>OCT. 19, 1963</u> and last saw him alive on <u>OCT 19, 1963</u> Death occurred at <u>6:15P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>H.R. Poring M.D.</u>		22b. ADDRESS <u>BALLWIN Mo.</u>	22c. DATE SIGNED <u>10-21-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>OCT-22-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ASSUMPTION Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>MATHESE Mo.</u>
24. FUNERAL DIRECTOR <u>Fey FUNERAL HOME, MEHLVILLE Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>10-21-63</u>	26. REGISTRAR'S SIGNATURE <u>John G. Murphy M.D.</u>

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT BY AFFIDAVIT OF

17 MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

1945-1946

**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

*Gustav W. Ginterle*

Licensed Embalmer No.

*4329*

P. O. Address

*St Louis Mo*

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.