DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 12 1946

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30790

Registration District No. 162 Primary Registration District No. 5595 Registrar's No. 34

1. PLACE OF DEATH:
(a) County Jefferson
(b) City or town Pevely (Rockstown township) (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Valley Park R.R. 1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jefferson
(c) City or town Near Murphy Rural (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? 86 years.

3. (a) PRINT FULL NAME Mathilda Kramer.
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W.
6. (a) Single, widowed, married, divorced W. 2
6. (b) Name of husband or wife Peter Kramer
6. (c) Age of husband or wife if alive 8 years
7. Birth date of deceased Feb (Month) 8 (Day) 1860 (Year)

8. AGE: Years 86 | Months 6 | Days 29 | If less than one day hr. min.

9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Housework Home
11. Industry or business
FATHER
12. Name Peter Hynes
13. Birthplace (City, town, or county) Va (State or foreign country)
MOTHER
14. Maiden name Martha Parker
15. Birthplace (City, town, or county) Ky. (State or foreign country)
16. (a) Informant's own signature Mrs Everett
(b) Address Murphy Mo. R1
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-9-46 (Month) (Day) (Year)
(c) Place: burial or cremation St Lucas Cem.
18. (a) Signature of funeral director Louis N. Baffo Mo
(b) Address Kirkwood Mo
19. (a) Sept 8-46 (Date received local registrar) (b) Phil J. Kirk (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 7 year 1946 hour minute 4 a M.
21. I hereby certify that I attended the deceased from Dec 1945 to Sept 7, 1946, that I last saw h alive on Sept 6-46, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Gangrene of foot	1 yr
Due to Diabetes	10 yrs
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations —
Of autopsy no

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? — (e) Means of injury —

23. Signature W. L. Dalton (M. D. or other)
Address Fenton Mo Date signed 9/12/46

(Licensed Embalmer's Statement on Reverse Side)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED
District Health Officer No. 9,
District File Number 2-46-100
Date Filed 9-10-46

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Felix Durand

Licensed Embalmer No. 3034

P. O. Address Kirkwood (2

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. a 1

Registration District No. 162 — Primary Registration District No. 5590 — Registrar's No. 34

1. PLACE OF DEATH:

(a) County Jefferson

(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Mathilda Kramer

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Feb 8 (Month) (Day) (Year)

8. AGE: Years 86 | Months 6 | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (State or foreign country)

10. Usual occupation House Work

11. Industry or business Home

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 10-10-46 (Date received local registrar) (b) Philip J. Kurtz (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 8 year 1946 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

30790