

Registration District No. 791 Primary Registration District No. _____

1. PLACE OF DEATH: 1008
(a) County _____
(b) City or town St. Louis FILED FEB 27 1940
(c) Name of hospital or institution: Mo. Baptist Hospital
(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)

3. (a) PRINT FULL NAME Robert Kranefield
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife Lillie Kranefield 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sep. 24 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 3 23 hr. min.

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

10. Usual occupation Mechanical Blacksmith

11. Industry or business Retired

12. Name Julius Kranefield

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Minnie Breme

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Elmer Stammers

(b) Address 9415 Muriel Overland, Mo.

17. (a) Burial (b) Date thereof 1-18-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles Park

18. (a) Signature of funeral director Wm. J. Brodie

(b) Address 2501 Woodson Rd - Overland, Mo.

19. (a) JAN 19 1940 (b) _____
(Date received local registrar) (Registrar's name)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Overland NR
(If outside city or town limits, write "RURAL")
(d) Street No. 9415 Muriel Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 50 YEARS years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Jan day 16
year 1940 hour 2 minute 30 am.
21. I hereby certify that I attended the deceased from Jan 15
1940, to Jan 16, 1940
that I last saw him alive on Jan 15, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
my cardiac cause 7 days
infection
Due to Parkinson's Disease 17 yrs
Due to arterio sclerosis death

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: _____ PHYSICIAN _____
Of operations _____
Of autopsy _____
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?

While at work? _____ (Specify type of place) (or) Means of injury _____
23. Signature Chas. A. Cole (M.D. or type) _____
Address 1506 Woodson Date signed 1-18-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39
1 X1811

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important

Dr. Charles A. Soc

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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.....

working under my personal supervision.

*Oscar F. Mueller
3039
Overland, Mo.*

....., Registered Apprentice No.

Signed.....

E. H. Allen

Licensed Embalmer No. *3501*

P. O. Address. *Overland 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 this body is not embalmed, above space should be left blank.