

No. 300
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FEDERAL BUREAU OF INVESTIGATION
National Office of Vital Statistics
FILED DEC 23 1948

318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

1003

41795

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. **10850**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
3723 N. 25th Street
(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 **Kate Rosenkrantz**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Richard** 6. (c) Age of husband or wife if alive **Dec'd.** years

7. Birth date of deceased **October 31 1881**
(Month) (Day) (Year)

8. AGE: Years **67** Months **1** Days **14** If less than one day hr. min.

9. Birthplace **St. Louis Missouri**
(City, town, or country) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **Home**

12. Name **Charles Price**

13. Birthplace **St. Louis Missouri**
(City, town, or country) (State or foreign country)

14. Maiden name **Katherine Reinhardt**

15. Birthplace **St. Louis Missouri**
(City, town, or country) (State or foreign country)

16. (a) Informant **Russell Rosenkrantz**

(b) Address **3723 N. 25th St.**

17. (a) **Burial** (b) Date thereof **12/17/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peters Cemetery**

18. (a) Signature of funeral director **PROVOST UND. CO.**

(b) Address **3710 N. Grand Blvd.**

19. (a) **DEC 15 1948** (b) **J. B. Lauster**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **3723 N. 25th Street**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **15**
year **1948** hour **2** minute **20 A M.**

21. I hereby certify that I attended the deceased from **14 Dec 1948** to **15 Dec 1948**
that I last saw her alive on **14 Dec 1948**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis**
Infarction Duration **24 hrs**

Due to _____
Due to **9 HA**

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?

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature **A. H. Carter Hoff** (M. D. or other) **15 Dec 48**
Address **634 N. Grand** Date signed **15 Dec 48**

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

MOTHER {

Dr. H. R. Calkenhoff
No. 221216 P. 168

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 Albert Mayfield
Licensed Embalmer No. 3077

P. O. Address.....

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, fact should be so stated above.