MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

File No. 28672

Registered No. 8208

1. PLACE OF DEATH

County ..... Registration District No. 701

Township ..... Primary Registration District No. .....

City St. Louis (No. City Hospital ..... St. ..... Ward)

2. FULL NAME 6012 Nick Rauch

(a) Residence. No. 1809 A 3 St., 23 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Kate Rauch

6. DATE OF BIRTH (MONTH, DAY AND YEAR) abt 1862

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
abt	65			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Hungary

PARENTS

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Hungary

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Hungary

14. INFORMANT City Hospital Informant
(Address) City Hospital

15. FILED SEP 16 1927, 19... Maple Starkloff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 15 1927

17. I HEREBY CERTIFY, That I attended deceased from August 8, 1927, to Sept 15 1927, that I last saw h. alive on Sept 15, 1927, and that death occurred, on the date stated above, at 1:40 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lateral Hemiplegia
HAD
9/11
..... (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) Arteriosclerosis
..... (duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) Johnston ..... M. D.
9/15, 1927 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
S. S. Peter & Paul	9-17 1927
20. UNDERTAKER	**ADDRESS**
F. C. Moydell	1926 Allen

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.

PERMANENT RECORD

Rauch,