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

Do not use this space.

34804

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

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

File No. ..... Registered No. 9942

2. FULL NAME August Rau

(a) Residence. No. 5800 Arsenal St., 13 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? 50 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Marie Rau

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 4/14/1855

7. AGE: Years 72 | Months 6 | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

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

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

PARENTS

10. NAME OF FATHER: Andrew J Rau

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

12. MAIDEN NAME OF MOTHER: ? Unknown

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

14. INFORMANT: Marie Smith Effingler
(Address) 5800 Arsenal

15. FILED NOV -7 1927 Max C Starkloff, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11/6 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov 1, 1927, to Nov. 6, 1927, that I last saw h. alive on Nov 6, 1927, and that death occurred, on the date stated above, at 6:40 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(C.V.R.) – Chr. Myocarditis
Chr. Valvular Renal disease

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Nephritis Chronic

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? .....
IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? Eye Reflexes - Heart

(Signed) Kenneth L. Wood, M. D

, 19 (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: Mo. Crematory — DATE OF BURIAL: Nov 8 1927

20. UNDERTAKER: A. Schumacher — ADDRESS: 3013 Miramee

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.