

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

Do not use this space.

37894

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... Primary Registration District No. **1003**
 City **St. Louis** (No. **1323**) **Hebert**

File No.
 Registered No. **11037**
 St. Ward)

2. FULL NAME

(a) Residence. No. **1323** **Hebert** St. **26** Ward.
 (Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED **Widow**
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Gustav F. Raasch**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Jan. 16, 1849**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
81 10 4

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

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

PARENTS

10. NAME OF FATHER **Not Known**
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Germany**
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER **Not Known**
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Germany**
 (STATE OR COUNTRY)

14. INFORMANT **Mrs. Mary Schaeffer**
 (Address) **1223 Hebert Street**

15. FILED **NOV 22 1930** **W. H. C. Townsend** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Nov. 30 1930**

17. I HEREBY CERTIFY, That I attended deceased from **Sept 15 1930** to **Nov 20 1930** that I last saw him alive on **Nov 19 1930** and that death occurred, on the date stated above, at **6:15 P. M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis

930
 (duration) ? yrs. mos. ds.

CONTRIBUTORY **Arteriosclerosis**
 (SECONDARY) (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) **Seth P. Smith**, M. D.
Nov 21, 1930 (Address) **4500 Clarence Ave**

*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 **St. Peters** DATE OF BURIAL **Nov. 24 1930**

20. UNDERTAKER **Math. Hermany & Son** ADDRESS **2161 E. Fair Cui.**

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.

