

FILED SEP 8 1944

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **7547**

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:
4450 Virginia Avenue
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community **45 years**
 years, months or days)

3. (a) PRINT FULL NAME **Frank C. Raumschuh**

3. (b) If veteran, name war _____ 3. (c) Social Security No. **492-05-1962**

4. Sex **Male** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Mrs. Julia Raumschuh**
 6. (c) Age of husband or wife if alive **62** years
 7. Birth date of deceased **July 24 1878**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 1 5 hr. _____ min.

9. Birthplace **Weingarten, Missouri**
 (City, town, or county) (State or foreign country)

10. Usual occupation **Machinist**

11. Industry or business **Sheet Metal Works**

MOTHER FATHER { 12. Name **Carl Raumschuh**
 13. Birthplace **Missouri**
 (City, town, or county) (State or foreign country)
 14. Maiden name **Unknown**
 15. Birthplace **Unknown**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Julia Raumschuh**
 (b) Address **3215 Taft Avenue**

17. (a) **Burial** (b) Date thereof **Aug. 31, 1944**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove Mausoleum**

18. (a) Signature of funeral director **Beiderwieden F.H., Inc.**
 (b) Address **1936 St. Louis Avenue**

19. (a) **AUG 31 1944** (b) **J. F. Bredeek**
 (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. **3215 Taft Avenue** (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **8** day **29**
 year **1944** hour **8** minute **03** A.M.

21. I hereby certify that I attended the deceased from **12-4**
 19 **43** to **8-29** 19 **44**
 that I last saw him **in** active on **8-27** 19 **44**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Disease** Duration _____

Due to **Myocarditis Chronic**

Other conditions **None**
 (Include pregnancy within 3 months of death)

Major findings: **None**
 Of operations _____
 Of autopsy **None**

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) (e) Means of injury _____
 23. Signature **Philip Schuck** (M. D. or other) **MD.**
 Address **703 Grand** Date signed **8-30-44**

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

Dr Philip Schuck
Grand + Lafayette

7-8 p.m.

9-10 a.m.

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.....

Licensed Embalmer No. 3737

P. O. Address 1936 St. Louis

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.