

FILED NOV 30 1944
318

Registration District No. _____

Primary Registration District No. **1002**

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:
5518 Greer Ave.
(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 **Fred. Wm. Rabenneck**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Louisa Rabenneck** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **March 3rd, 1871**
(Month) (Day) (Year)

8. AGE: Years **73** Months **8** Days **12** If less than one day hr. _____ min. _____

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

10. Usual occupation **Watchman**

11. Industry or business **Retired**

12. Name **Fred W. Rabenneck**

13. Birthplace **Germany** (City, town, or county) (State or foreign country)

14. Maiden name **Henretta Kobolt**

15. Birthplace **Germany** (City, town, or county) (State or foreign country)

16. (a) Informant **Wm. Rabenneck**

(b) Address **5518 Greer Ave.**

17. (a) **Burial** (b) Date thereof **11-18-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Drehmann-Harral**

(b) Address **1905 Union Blvd.**

19. (a) **NOV 16 1944** (Date received local registrar) **J. F. Bredeck** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
(d) Street No. **5733 Lotus Av** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov.** day **15th** year **1944** hour **9** minute **05P** M.

21. I hereby certify that I attended the deceased from **April 24**, 19**44**, to **Nov. 15**, 19**44**, that I last saw him alive on **Nov. 11**, 19**44**, and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of stomach**
Due to _____
Due to **Hf6**
Other conditions **arteriosclerosis**
(Include pregnancy within 3 months of death)

Duration

PHYSICIAN

Major findings:
Of operations _____
Of autopsy _____
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 **J. F. Bredeck** (M. D. or other) **M.D.**
Address **375 Washington** Date signed **11/16/44**

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

MOTHER FATHER

Warren A. Carver

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 *Warren A. Carver*

Licensed Embalmer No. *3534*

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.