S. No. 2
M—5-43
. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED DEC 28 1945

State File No. 39667

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10887

1. PLACE OF DEATH:

(a) County

(b) City or town Saint Louis, Missouri.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 4037 Walsh Street. /
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 14

(c) City or town Saint Louis, 15
(If outside city or town limits, write "RURAL")

(d) Street No. 4037 Walsh
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Minnie Rasp

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female /

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed. 2

6. (b) Name of husband or wife Edward Rasp

6. (c) Age of husband or wife if alive years

7. Birth date of deceased October 8th, 1874.
(Month) (Day) (Year)

8. AGE: Years 71 Months 2 Days 5 If less than one day hr. min.

9. Birthplace Saint Louis (City, town, or county) Missouri. (State or foreign country)

10. Usual occupation At Home.

11. Industry or business

FATHER
12. Name August Bieger
13. Birthplace Germany (City, town, or county) 4 (State or foreign country)

MOTHER
14. Maiden name Josephine Berg.
15. Birthplace Unknown (City, town, or county) 4 (State or foreign country)

16. (a) Informant Mrs H. H. Fox
(b) Address 4037 Walsh Street.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 17, 1945. (Month) (Day) (Year)
(c) Place: burial or cremation New St. Marcus Cemetery.

18. (a) Signature of funeral director Ziegenhein Bros.
(b) Address 6409 Gravois. Ave.

19. (a) DEC 14 1945 (Date received local registrar) (b) J. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December 13th, year 1945. hour 10 30 minute P. M. (P.M.)

21. I hereby certify that I attended the deceased from 11/26/1945, 19, to 12/13, 1945 that I last saw her alive on 12/13/45, 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Cerebral Haemorrhage — 12 hours.

Due to

Due to

Other conditions Hypertension — 6 months
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Elsie Simpson (M. D. or other) M.D.

Address 3739 Gravois ave. Date signed 12/14/45

(Licensed Embalmer's Statement on Reverse Side)

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 Homer W Fritz

Licensed Embalmer No. 3882

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.