

Registration District No. **37**

Primary Registration District No. **3069**

1. PLACE OF DEATH:
(a) County **St. Louis**
(b) City or town **Richmond Heights**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **10 years** (Specify whether years, months or days)

In this community **10 years** (Specify whether years, months or days)
3. (a) PRINT FULL NAME **(nee Clara C. Rauwolf) Sister Mary Christella, S. S. M.**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **none**

4. Sex **F** / 5. Color or race **W**
6. (a) Single, widowed, married, divorced **Single**
6. (c) Age of husband or wife if alive **30** years (Day) (Year)
7. Birth date of deceased **May 30 1901**
(Month) (Day) (Year)

8. AGE: Years **45** Months **6** Days **20**
If less than one day hr. min.

9. Birthplace **Blue Island Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Sister in Religion**
11. Industry or business **St. Mary's Hospital**

MOTHER FATHER
12. Name **Joseph F. Rauwolf**
13. Birthplace **Blue Island Illinois**
(City, town, or county) (State or foreign country)
14. Maiden name **Elizabeth Simon**
15. Birthplace **Baltimore Maryland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Rev. Mother Concordia**
(b) Address **1100 Bellevue**

17. (a) **Burial** (b) Date thereof **Dec. 23 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Old St. Peter & Paul**

18. (a) Signature of funeral director **Watson Bocklage**
(b) Address **6536 Clayton Rd.**

19. (a) **2-23-46** (b) **Paul J. Bocklage**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **St. Louis**
(c) City or town **Richmond Heights**
(If outside city or town limits, write "RURAL")
(d) Street No. **1100 Bellevue Ave.**
(If rural, give location) **no**
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **20**
year **1946** hour minute M.
21. I hereby certify that I attended the deceased from **9-9**
to **12-20** 19 **46**
that I last saw her alive on **12-19** 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cos. Cranium** Duration
of herpes m. to stroke
480

Due to **Adeno Cos. Cranium**
Due to **Adeno Cos. Cranium**
Other conditions **Adeno**
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings **Adeno Cos. Cranium**
Of operations **Adeno 4-18-47**
Of autopsy **none**
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) **no**
(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) (c) Means of injury
23. Signature **James J. ...** (M. D. or other)
Address **1100 Bellevue Ave.** Date signed **12/20/46**

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

J Allen Davis Jr

Licensed Embalmer No. *4053*

P. O. Address *St Louis Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.