

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X3667

FILED MAR 24 1947
Registration District No. _____

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Barnes Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 days
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Louis Townsend Rash

3. (b) If veteran, name war. No

3. (c) Social Security No. Unknown

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Maude Lee Rash

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased September 13 1886
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>60</u>	<u>6</u>	<u>0</u>	hr. _____ min. _____

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

10. Usual occupation Store Owner

11. Industry or business Grocery

MOTHER FATHER {

12. Name Unknown

13. Birthplace Unknown
(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. Hattie Joiner

(b) Address Warwick Hotel

17. (a) Removal (b) Date thereof 3-14-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elizabethtown, Ill.

18. (a) Signature of funeral director Albert H. Hoppe
4700 Washington Blvd.

(b) Address 4700 Washington Blvd.

19. (a) Mar 24 1947 (b) J. F. Rudick
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Hardin

(c) City or town Rosiclare
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13
year 1947 hour 10 minute 55 AM.

21. I hereby certify that I attended the deceased from March 3
1947, to March 13 1947
that I last saw him in alive on March 13 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion
Duration 10 days

Due to Hypertensive cardiovascular disease 9 1/2 yrs 7 yrs

Due to _____

Other conditions Arteriosclerotic heart disease 7 yrs
(Include pregnancy within 3 months of death)

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 F. R. Rudick (M. D. or other) _____
Barnes Hospital
Address _____ Date signed 3-13-47

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 Elmer R. Cadwell

Licensed Embalmer No. 4077

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.