S. No. 300
v. 10-48

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

FILED JUL 25 1949 16499

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25202

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6131

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St.Louis,Mo.
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St.Louis City Hospital #1.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: 17
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St.Louis
d. STREET ADDRESS (If rural, give location): 1109½ N. 19th St.,

3. NAME OF DECEASED (Type or Print)
a. (First): PETE
b. (Middle):
c. (Last): RASKE

4. DATE OF DEATH (Month) (Day) (Year): July 3,1949

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: 6/29 abt - 63
9. AGE (In years last birthday): If under 1 year: Months, Days; If under 1 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia 6
12. CITIZEN OF WHAT COUNTRY?: ?

13a. FATHER'S NAME: John Raske
13b. MOTHER'S MAIDEN NAME: Mary unknown
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME / **ADDRESS**: M.Renard, St.Louis City Hospital #1.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of ~~esophagus~~ of Larynx

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 49a
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 161X

22. *I hereby certify that I attended the deceased from* 12/20/48 *19*____, *to* 7/3/49, *19*____, *that I last saw the deceased alive on* 7/3/49, *19*____, *and that death occurred at* 8:30am *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Paul M Cordwell M.D.
23b. ADDRESS: 1515 Lafayette Ave.,
23c. DATE SIGNED: 7/13/49

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE: JUL 14 1949
24c. NAME OF CEMETERY OR CREMATORY: Calvary Cem.
24d. LOCATION (City, town, or county) (State): St.Louis, Mo

DATE REC'D BY LOCAL REG.: JUL 14 1949
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE / **ADDRESS**: Cullen-Kelly - 4386 Sandell

(Licensed Embalmer's Statement on Reverse Side)

BL

No Embalming

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 .....

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed .....

Licensed Embalmer No. .....

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.