

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39190

FILED NOV 21 1949

State File No.

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 9597

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No.		Registrar's No. 9597						
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____										
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			c. LENGTH OF STAY (in this place) _____			c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			d. STREET ADDRESS (If rural, give location) 14 4990a Miami St. 90					
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital 0				d. STREET ADDRESS (If rural, give location) 14 4990a Miami St. 90										
3. NAME OF DECEASED (Type or Print) Theodore Rathgeber			a. (First) Theodore			b. (Middle) E.			c. (Last) Rathgeber			4. DATE OF DEATH (Month) (Day) (Year) 11/4/49		
5. SEX Male M		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Sept. 10, 1896		9. AGE (In years last birthday) 53		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman				10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (State or foreign country) St. Louis, Missouri			12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Frank Rathgeber				13b. MOTHER'S MAIDEN NAME Louise Etz				14. NAME OF HUSBAND OR WIFE Ida						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW #1				16. SOCIAL SECURITY NO. ---				17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ida Rathgeber--4990a Miami St.						
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) <i>arterio-sclerosis of brain & aneurism of cerebral vessel ruptured spontaneously</i>														
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.														
19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION <i>no operation</i>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <i>none</i>			21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____			21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 96, 11/5/49								
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR? <i>H52X</i>								
22. I hereby certify that I attended the deceased from <i>at noon 11-4, 1949</i> , to <i>11-4, 1949</i> , that I last saw the deceased alive on <i>11-4, 1949</i> , and that death occurred at <i>6:10 p.m.</i> , from the causes and on the date stated above.														
23. SIGNATURE <i>Joseph & Don Gabriel MD</i>						23b. ADDRESS <i>6-3 4th Grand</i>			23c. DATE SIGNED <i>11/5/49</i>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>11/8/49</i>		24c. NAME OF CEMETERY OR CREMATORY <i>St. Pauls Churchyard</i>			24d. LOCATION (City, town, or county) (State) <i>St. Louis Co., Missouri</i>							
DATE REC'D BY LOCAL REG. <i>NOV 7 1949</i>		REGISTRAR'S SIGNATURE <i>J.B. ...</i>				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Wacker-Heldene 3634 Gravois</i>								

NOV 28 1949

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

Delis J. Krupin

Licensed Embalmer No. _____

3497

P. O. Address _____

3634 Grant

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.