

FILED DEC 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39800

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 4428

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

1. PLACE OF DEATH a. COUNTY St. Louis		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 Koch (rural)		c. LENGTH OF STAY (in this place) 130 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital		e. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
		f. STREET ADDRESS (If rural, give location) 6926 Waldemar	

3. NAME OF DECEASED (Type or Print)	a. (First) Catherine	b. (Middle) Elizabeth	c. (Last) Raatz	4. DATE OF DEATH (Month) (Day) (Year) 11-15-49
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 11-30-94	9. AGE (In years last birthday) 54	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher	10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) South Dakota	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Jacob Raatz	13b. MOTHER'S MAIDEN NAME Catherine E. Alles	14. NAME OF HUSBAND OR WIFE -
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 498-16-5103	17. INFORMANT'S SIGNATURE OR NAME Hospital Records, Robt. Koch Hosp.	ADDRESS
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 19 days 19 years DO2X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Throcooplasty		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pulmonary Tuberculosis 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	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-8-49, 19, to 11-15, 1949, that I last saw the deceased alive on 11-15-1949, and that death occurred at 1:30A. m., from the causes and on the date stated above.

23a. SIGNATURE Bernard Friedman (Degree or title) M.D.	23b. ADDRESS Robert Koch Hospital	23c. DATE SIGNED 11-15-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 18-1949	24c. NAME OF CEMETERY OR CREMATORY Oakwood	24d. LOCATION (City, town, or county) (State) Alton Ill.
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DATE REC'D BY LOCAL REG. Nov. 17, 1949	REGISTRAR'S SIGNATURE Herbert R. Donke, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE O. Carson	ADDRESS Alton Ill.
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FEB 13 1954

MAR 10 1954

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.....

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working under my personal supervision.

Student Embalmer No.....

Signed *Harold Quinn*

Signed.....
Student Embalmer

Licensed Embalmer No. 5796

P. O. Address Alton Ill

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.