

FILED OCT 27 1950

STANDARD CERTIFICATE OF DEATH

State File No. 35245

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002 Registrar's No. 8891

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE Mo. b. COUNTY |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>St Louis Mo |  | c. CITY (If outside corporate limits, write RURAL and give township)<br>St. Louis 2069                           |  |
| c. LENGTH OF STAY (In this place)<br>25 Yrs   |  | d. STREET ADDRESS (If rural, give location)<br>5255 Terry Ave.   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br>St Louis State Hosp.                     |  |  |  |

|   |                           |   |   |
|---|---------------------------|---|---|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) Frank b. (Middle) c. (Last) Ratican |                           | 4. DATE OF DEATH (Month) (Day) (Year)<br>10 - 19 - 1950   |   |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br>Separated   | 8. DATE OF BIRTH<br>11 - 20 - 1889                |
| 9. AGE (In years last birthday)<br>60   |                           | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Auto mechanic | 11. BIRTHPLACE (State or foreign country)<br>Iowa |
| 10b. KIND OF BUSINESS OR INDUSTRY   |                           | 12. CITIZEN OF WHAT COUNTRY<br>USA  |   |

|   |                                      |  |
|---|--------------------------------------|--|
| 13a. FATHER'S NAME<br>C.J. Ratican  | 13b. MOTHER'S MAIDEN NAME<br>Unknown | 14. NAME OF HUSBAND OR WIFE<br>Unknown   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>Unknown | 16. SOCIAL SECURITY NO.              | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br>Mrs. Albert Listrom 5255 Terry Ave. |

|   |   |  |  |
|---|---|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |  | INTERVAL BETWEEN ONSET AND DEATH<br>10 min |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion   |  |  |
|   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) Arteriosclerotic Heart Dis<br>DUE TO (c) Generalized Arteriosclerosis |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>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?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 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?<br>H201  |

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 6:15 p.m., from the causes and on the date stated above.

|  |                                       |   |
|--|---------------------------------------|---|
| 23a. SIGNATURE<br>A. Frederick Heesler M.D.                    | 23b. ADDRESS<br>St Louis State Hosp   | 23c. DATE SIGNED<br>10-19-50  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial            | 24b. DATE<br>10/21/50                 | 24c. NAME OF CEMETERY OR CREMATORY<br>Calvary Cemetery                          |
| 24d. LOCATION (City, town, or county) (State)<br>St. Louis Mo. |                                       | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br>Sullivan Funeral Dir/2849 N. Euclid |
| DATE REC'D BY LOCAL REG.<br>OCT 20 1950                        | REGISTRAR'S SIGNATURE<br>J. B. Foster |   |

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

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 \_\_\_\_\_

working under my personal supervision.

Signed.....  
Student Embalmer

Signed *Gustave Dieterle*  
Student Embalmer No. ....

Licensed Embalmer No. *329*

P. O. Address *St Louis*

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.