

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 17 1951

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **4464** Registrar's No. **42**

1. PLACE OF DEATH a. COUNTY ST LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE MISSOURI b. COUNTY ST LOUIS	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN OVERLAND		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN OVERLAND 423X	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2417 SPENCER		d. STREET ADDRESS (If rural, give location) 2417 SPENCER 0	

3. NAME OF DECEASED (Type or Print)	a. (First) MINNIE	b. (Middle)	c. (Last) RACKAWAY	4. DATE OF DEATH (Month) (Day) (Year) 1 - 6 - 51
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH SEPT 17 1873	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) ST LOUIS MO	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME ADAM MEYER	13b. MOTHER'S MAIDEN NAME ANNA SMITH	14. NAME OF HUSBAND OR WIFE WILLIAM H RACKAWAY (D)
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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. NO	17. INFORMANT'S SIGNATURE OR NAME WILLIAM J RACKAWAY	ADDRESS 2417 SPENCER
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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, asthma, etc. It means the disease, injury, or complication which caused death.	18. CAUSE OF DEATH DIRECTLY LEADING TO DEATH* (a) Carcinoma of Bowels		INTERVAL BETWEEN ONSET AND DEATH 2 yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	11. 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 type="checkbox"/> NO <input checked="" 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) 153X
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **4-10, 1950** to **1-5, 1951**, that I last saw the deceased alive on **1-5, 1951**, and that death occurred at **12:31 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE A F Berner (Degree or title) MD	23b. ADDRESS 1259 N. Knagsburgway	23c. DATE SIGNED 1-8-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 1-8-51	24c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK	24d. LOCATION (City, town, or county) (State) St. Louis, MO
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DATE REC'D BY LOCAL REG. 1/8/51	REGISTRAR'S SIGNATURE Robert P. Lombardi	FUNERAL DIRECTOR'S SIGNATURE BAUMANN BROTHERS INC	ADDRESS OVERLAND MO
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1 to 3 P. 100
New System

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 3454

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working under my personal supervision.

Student Embalmer No.

Signed

David C. Gibson

Signed.....
Student Embalmer

Licensed Embalmer No. 3454

P. O. Address Overland 1417

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.