

JUL 2 - 1952

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **22520**

BIRTH NO.		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No. 5573
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 10-yrs.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2129	
d. FULL NAME OF HOSPITAL OR INSTITUTION 5521 Waterman Ave.		d. STREET ADDRESS (If rural, give location) 12 5521 Waterman Ave.		
3. NAME OF DECEASED (Type or Print) Margaret		a. (First)	b. (Middle) Hawthorne	c. (Last) Raikes
4. DATE OF DEATH (Month) (Day) (Year) June 14, 1952		5. SEX F.		6. COLOR OR RACE W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) D. 2		8. DATE OF BIRTH Dec. 31, 1900		9. AGE (In years last birthday) 51
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Townsville, Penn.
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Archibald D. Hawthorne		13b. MOTHER'S MAIDEN NAME Henrietta Drake
14. NAME OF HUSBAND OR WIFE Arthur F.G. Raikes		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.
17. INFORMANT'S SIGNATURE OR NAME Charles F.G. Raikes, 4606 Maryland Ave.		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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES DUE TO (b) Heart Stroke 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 000		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? F9319
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 1:30 P. m., from the causes and on the date stated above. 22				
23a. SIGNATURE Joseph M. ...		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 6/16/52
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE June 17, 1952		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Nonnelly		ADDRESS 810 Lindell Blvd.
DATE REC'D BY LOCAL REG. JUN 16 1952		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____
W. Van Matre

Licensed Embalmer No. *3840 Sundell*

P. O. Address *2895*

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.