

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28065

FILED SEP 1 1955

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State File No.

Registrar's No. 6777

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No.											
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE				b. COUNTY									
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN				c. LENGTH OF STAY (In this place)		c. CITY OR TOWN		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
d. FULL NAME OF HOSPITAL OR INSTITUTION				• STREET ADDRESS (If rural, give location)		5379 Pershing		212/5									
3. NAME OF DECEASED (Type or Print)			a. (First)			b. (Middle)			c. (Last)								
WILLIAM			RASMUSSEN			SR.			4. DATE OF DEATH (Month) (Day) (Year)								
AUGUST			2			1955											
5. SEX		6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR (Months) (Days)		IF UNDER 12 HRS. (Hours) (Min.)					
MALE		WHITE		MARRIED		7-16-1888		67									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and State or Foreign Country)				12. CITIZEN OF WHAT COUNTRY?					
Advertising				Retired				St. Joseph, Missouri				U.S.A.					
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE									
Augusta Rasmussen				Martha				Bertha									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT'S SIGNATURE OR NAME				ADDRESS					
No								Bertha Rasmussen, 5379 Pershing									
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION								INTERVAL BETWEEN ONSET AND DEATH					
<p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)								36 hours					
				<p>ANTECEDENT CAUSES</p> <p>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</p> <p>DUE TO (b)</p> <p>DUE TO (c)</p>													
				<p>II. OTHER SIGNIFICANT CONDITIONS</p> <p>Conditions contributing to the death but not related to the disease or condition causing death.</p> <p>None</p>													
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
												4200					
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) (m.)				21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21f. HOW DID INJURY OCCUR?									
22. I hereby certify that I attended the deceased from 1 Aug, 1955, to 2 Aug, 1955, that I last saw the deceased alive on 2 Aug, 1955, and that death occurred at 12:45 m., from the causes and on the date stated above.																	
23a. SIGNATURE (Degree or title)						23b. ADDRESS						23c. DATE SIGNED					
Warren M. Lorenz, MD						457 N. Kings Highway						8-2-55					
24a. BURIAL, CREMATION, REMOVAL (Specify)				24b. DATE				24c. NAME OF CEMETERY OR CREMATORIUM				24d. LOCATION (City, town, or county) (State)					
REMOVAL				8-5-1955				St. Paul's Churchyard				St. Louis Co. Missouri					
DATE REC'D BY LOCAL REG.				REGISTRAR'S SIGNATURE				25. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS					
AUG 4 1955				[Signature]				McLaughlin F.H., Inc.				2301 Lafayette					

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 Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed..... *L R Cooper*

Licensed Embalmer No. *2637*
P. O. Address *2501 Lafayette St. Miami*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.