

FILED MAR 26 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **11289**  
**2158**BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis,</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>4044 Ferguson</b>	
c. LENGTH OF STAY (in this place) <b>1 yr.</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis Chronic Hosp.</b>		e. STREET ADDRESS (If rural, give location) <b>10103 Green Valley, Dr.</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) _____	b. (Middle) _____	c. (Last) _____	4. DATE OF DEATH (Month) (Day) (Year)
	<b>Augusta Rahmberg</b>			<b>2-27-56</b>

5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widow</b>	8. DATE OF BIRTH <b>2-26-1869</b>	9. AGE (In years last birthday) <b>87</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Sweden</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>August Mattson</b>	13b. MOTHER'S MAIDEN NAME <b>Suzanna ?</b>	14. NAME OF HUSBAND OR WIFE <b>Charles M. Rahmberg</b>
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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) <b>No.</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Arthur Rahmberg</b>	ADDRESS <b>10103 Green Valley, Dr.</b>
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hypertensive Cardiovascular Disease</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Disease</b> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Central Arteriosclerosis Terminal Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>443 X</b>	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)
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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?
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22. I hereby certify that I attended the deceased from **9-16-54**, 19\_\_\_\_, to **2-27-56**, 19\_\_\_\_, that I last saw the deceased alive on **2-27-56**, 19\_\_\_\_, and that death occurred at **3:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>George M. Skalka, M.D.</b> (Degree or title)	23b. ADDRESS <b>5600 Arsenal St.</b>	23c. DATE SIGNED <b>Feb. 28, 1956</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>2-29-56</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Friedens Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis, County, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>FEB 29 1956</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b>	ADDRESS <b>4700 Washington,</b>
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S.P. (Licensed Embalmer's Statement on Reverse Side)

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

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.