

FILED APR 12 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10914

STATE FILE NUMBER 2770

Registration District No. 318 Primary Registration District 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>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE <b>St. Anthony Hospital</b>				Length of stay in lb <b>53 yrs 2/15</b>		STREET ADDRESS (If outside, give location) <b>4170 Itaska Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>RAFFEL</b> Last <b>RAFFEL</b>				4. DATE OF DEATH Month <b>Mar.</b> Day <b>19</b> Year <b>1957</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4, 1904</b>	9. AGE (In years last birthday) <b>53</b>	IF UNDER 1 YEAR Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min.	IF UNDER 24 HRS. Hours <b>53</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>freight handler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>shipping</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JACOB RAFFEL</b>				14. MOTHER'S MAIDEN NAME <b>MINNIE HOFFMANN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>488-09-7306</b>		17. INFORMANT Address <b>Mrs. Myrtle Raffel, 4170 Itaska Avenue</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Delayed Pulverulent Pneumonia</b> DUE TO (b) <b>Chronic Lung infection of unknown origin at this time</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>3/5/57</b> <b>Dec 1954</b>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>492x</b>				
20c. TIME OF INJURY Hour _____ a. m. _____ p. m.			20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		CITY, TOWN, OR LOCATION		STATE	
21. I attended the deceased from <b>Dec 1954</b> to <b>March 19 1957</b> and last saw <b>him</b> alive on <b>3/19/57</b> Death occurred at <b>10:00 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Dr. Carl Smith, M.D.</b>				22b. ADDRESS <b>5417 Do Grand Blvd.</b>		22c. DATE SIGNED <b>3/20/57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>Mar. 22, 1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>	
24. FUNERAL DIRECTOR ADDRESS <b>BEIDERWLEDEN F. H. INC., 1936 St. Louis</b>				25. DATE RECD. BY LOCAL REG. <b>MAR 21 '57</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b> <b>S.P.</b>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Securing the medical certificate to the body is the responsibility of the funeral home.

300 1-56

Health, Welfare, Public Service

Dr. Emmett Rund  
5417 So. Grand

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 David J. [Signature]

Licensed Embalmer No. 45

P. O. Address [Signature]

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.