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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003413
STATE FILE NUMBER

FILED JAN 28 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 276

1. PLACE OF DEATH a. COUNTY	**2. USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St.Louis — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN St.Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 821a Bremen Ave. — Length of stay in Hospital 30 yrs.	d. STREET ADDRESS (If outside, give location) 821a Bremen Ave. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month Day Year
Ethel	E.	Rath	January 8, 1959

5. SEX	6. COLOR OR RACE	7. MARITAL STATUS	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	July 30,1893	65				

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 country)	12. CITIZEN OF WHAT COUNTRY?
Retired Inspectress	Hotel	Divernon,Ill.	U.S.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Alec Ford	Molly Rogers	William Rath

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	Address
No			James W.Hodges,	821a Bremen Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Hemorrhage

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Hypertension

DUE TO (c) Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 331X

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Dec 2-58 to Jan 8-59 and last saw her alive on 1/6/59

Death occurred at 1/8/59 7 AM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE	(Degree or title)	22b. ADDRESS	22c. DATE SIGNED
Otto C. Hanser	MD	301 Lafayette	1/9/59

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Removal	1-10-59	Memorial Park Cemetery	St.Louis Co.,Mo.

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Albert H.Hoppe,	4700 Washington Blvd.	JAN 9 '59	Earl Smith MD

MJB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 Geo. W. Wilkinson

Licensed Embalmer No. 357

P. O. Address St. Louis

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.