

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032850

FILED VS SEP 24 1959

160

Primary Registration District No.

559

Registrar's No.

137

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Jefferson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Festus		c. CITY OR TOWN St. Louis	
Length of stay in 1b 3 weeks		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mountain View Convalescent		d. STREET ADDRESS (If outside, give location) 4973 Tholozan	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) MINNIE MAE RASMUSSEN	First MINNIE	Middle MAE	Last RASMUSSEN	4. DATE OF DEATH September 15, 1959
				Month September
				Day 15
				Year 1959

5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1876	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months 9 Days 15 Hours Min. 	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Clinton, Illinois	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME Samuel Kirk	13b. MOTHER'S MAIDEN NAME Bertha Razy	14. NAME OF HUSBAND OR WIFE Walter R. Rasmussen
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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) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. Vernon Rasmussen, 7833 Stanford
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 3 Days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.)
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20c. TIME OF INJURY Hour a.m. p.m. 	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <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 St. Louis	COUNTY Missouri	STATE Missouri
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21. I attended the deceased from **8/23/59** to **Sept. 15, 1959** and last saw her alive on **Sept. 15, 1959**
Death occurred at **3:15 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>	Degree or title MD	22b. ADDRESS Pacific Ave. Crystal City, Mo	22c. DATE SIGNED Sept. 16, '59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Sept. 18, 1959	23c. NAME OF CEMETERY OR CREMATORY Valhalla Mausoleum	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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24. FUNERAL DIRECTOR Ambruster Mortuary, 6633 Clayton Rd.	25. DATE RECD. BY LOCAL REG. 9-16-59	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

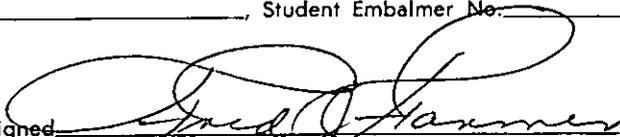
BY AFFIDAVIT OF

SEP 24 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed  _____

Licensed Embalmer No. 4788

P. O. Address St. Louis

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