

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-034207**

**FILED VS OCT 15 1959**

Primary Registration District No. \_\_\_\_\_

Registrar's No. **2 8946**

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>9 years</b>	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 INSTITUTION <b>5811 Sutherland</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5811 Sutherland</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph Franklin Raber</b>			4. DATE OF DEATH Month Day Year <b>September 26, 1959</b>			
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</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>2/9/1905</b>	9. AGE (last birthday) <b>54</b>	IF UNDER 1 YEAR Months Days 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) <b>Vice Pres. J. Gordon Co.</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Ind. Sound Equipment</b>	11. BIRTHPLACE (City and state or country) <b>Connersville, Ind.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Joseph Raber</b>	13b. MOTHER'S MAIDEN NAME <b>Edith Winters</b>	14. NAME OF HUSBAND OR WIFE <b>Bearta Raber (nee Gordon)</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>480-09-4967</b>	17. INFORMANT Address <b>Talmadge Gordon, 7939 Lorine, Maplewood</b>
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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) <b>Acute Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Ductal</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<b>420.1</b>

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	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 COUNTY STATE
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21. I attended the deceased from <b>August 1959</b> , to <b>9-25-59</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>9-22-59</b> Death occurred at <b>6:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Robert H. Smith, M.D.</b>	22b. ADDRESS <b>6500 Chippewa</b>	22c. DATE SIGNED <b>9-28-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9/29/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>2000 Pennsylvania Ave. St. Louis</b>
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24. FUNERAL DIRECTOR ADDRESS <b>Hofmeister Colonial Mortuary 6464 Chippewa Street, St. Louis, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>SEP 29 1959</b>	26. REGISTRAR'S SIGNATURE <b>Roan Smith, M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

2226

**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 Levin E. Hoffmeister

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broad

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.