

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-044757

FILED VS NOV 28 1960

317

Primary Registration District No. 500

Registrar's No. 3372

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		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, give TOWNSHIP only) OR TOWN <b>Bellefontaine Neighbors</b>	Length of stay in 1b <b>26 mo.</b>	c. CITY OR TOWN <b>Bellefontaine Neighbors</b>	Inside Limits a. <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>826 Fontaine Place</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>826 Fontaine Place</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Frederick</b> Middle <b>William</b> Last <b>Rahing</b>			4. DATE OF DEATH Month <b>11</b> Day <b>17</b> Year <b>60</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/23/1873</b>	9. AGE (last birthday) <b>87</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cutlery Buyer - Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hardware</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Charles H. Rahing</b>		13b. MOTHER'S MAIDEN NAME <b>Charlotte Frovitter</b>		14. NAME OF HUSBAND OR WIFE <b>Anna M. Rahing</b>			
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>494-10-7442</b>		17. INFORMANT Address <b>Mrs. Dorothy Goebel, 826 Fontaine</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>HYPERTENSION</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.)	
20c. TIME OF INJURY Hour <b>5:00</b> 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

21. I attended the deceased from **9/1/59** to **11/17/60** and last saw <sup>her</sup>him alive on **10/22/60**  
Death occurred at **5:00** a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Earl W. Lavinie M.D.</b>		22b. ADDRESS <b>6000 WEST FLORENCE</b>		22c. DATE SIGNED <b>11/18/60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>11/19/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Drehmann-Harral 1905 Union</b>		25. DATE RECD. BY LOCAL REG. <b>11-19-60</b>	26. REGISTRAR'S SIGNATURE <b>John G. Murphy M.D.</b>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 13 1961

**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 Albert R. Thompson

Licensed Embalmer No. 4257

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.