

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9979**

FILED NOV 8 1961

1. PLACE OF DEATH
 a. COUNTY _____
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis, Mo** Length of stay in 1b **11 Days**
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **St. Louis Children's Hosp** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE **Illinois** b. COUNTY **Calhoun**
 c. CITY OR TOWN **Hardin Ill** Inside Limits Yes No
 d. STREET ADDRESS _____ (If outside, give location) Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year
Charles Leo Raich **10-27-1961**

5. SEX **Male** 6. COLOR OR RACE **White** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **10-6-61** 9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR
20 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **None** 10b. KIND OF BUSINESS OR INDUSTRY **None** 11. BIRTHPLACE (City and state or country) **Jerseyville Ill** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **Charles Raich, Jr.** 13b. MOTHER'S MAIDEN NAME **Margaret Busch** 14. NAME OF HUSBAND OR WIFE **Single**

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 **Alice Trowbridge, 500 S. Kingshighway** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Cardiac arrest**
 DUE TO (b) **Atrio-Ventricular Communes**
 DUE TO (c) **754.5**

INTERVAL BETWEEN ONSET AND DEATH _____

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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____

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

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 **10-16-61** to **10-27-61** and last saw her him alive on **10-27-61**
 Death occurred at **2:15 AM** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE **Robert H. Chavanne M.D.** (Degree or title) 22b. ADDRESS **500 S. Kingshighway** 22c. DATE SIGNED **10/27/61**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **10/28/61** 23c. NAME OF CEMETERY OR CREMATORY **Mt. Olive Cemetery** 23d. LOCATION (City, town, or county) **St. Louis County, Mo.** (State)

24. FUNERAL DIRECTOR **CHILICK UND. CO. 1722 S. Jefferson** ADDRESS 25. DATE RECD. BY LOCAL REG. **OCT 27 1961** 26. REGISTRAR'S SIGNATURE **Lead Smith, M.D.**

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

V E Morris

Licensed Embalmer No. 3360

P. O. Address St Louis, Mo

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.