

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

SEP 25 1934

30687

1. PLACE OF DEATH

County St. Louis Registration District No. 790
 Township Central Precinct Registration District No. 6033A
 City Clayton (No. St. Louis Co. Hospital) St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 5626 Janet St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Katherine Rausch

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 15 1863

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>71</u>	<u>5</u>	<u>29</u>	

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Labourer
 10. Date deceased last worked at this occupation (month and year).....
 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Austria

13. NAME Don't know.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D. K.

15. MAIDEN NAME Don't know.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Mrs. Katherine Rausch
5626 Janet Ave

18. BURIAL, CREMATION, OR REMOVAL PLACE Coburn DATE 8/16-1934

19. UNDERTAKER (ADDRESS) W. A. Stockm. Co.
2117 E. 1st St.

20. FILED 8/24 1934 of Root, J. A. (Address) _____
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 14 1934

22. I HEREBY CERTIFY, That I attended deceased from 8-12, 1934, to 8-14, 1934

I last saw him alive on 8-13, 1934. Death is said to have occurred on the date stated above, at 8:25 a.m.

The principal cause of death and related causes of importance, were as follows:

Chronic myx carditis
Encephalitis
MI
 Other contributory causes of importance:

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

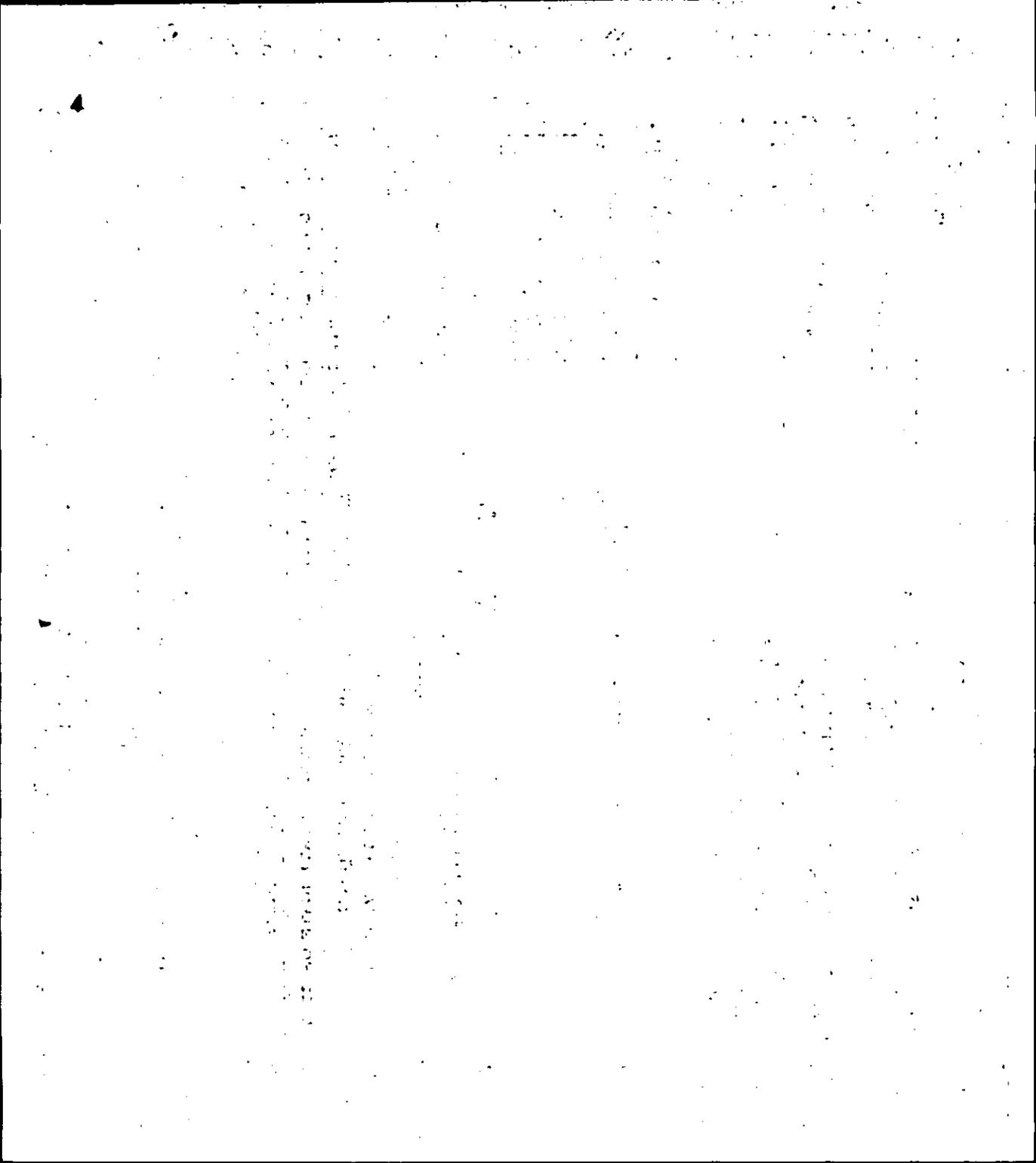
24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify.....

(Signed) H. C. Carpenter, M. D.
 (Address) S. F. Louis Co. Hospital

Date of onset

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Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Frank Rausch
Who died at _____ on Aug - 14 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex M Color or race W Single, married, widowed or divorced:

Date of birth _____ Age: Years 71 Months 5 Days 29

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month 11 Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Chronic Myocarditis Encephalitis (Epicardial type)

Other contributory causes of importance _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

(Signature of Registrar Robt J. Cankruster) Date filed _____

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 790

Very truly yours,

E. T. McLaugh

State Registrar
Special Agent.

Primary Reg. Dist. No. 6033a

S-30687

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