

Registration District No. **791**

Primary Registration District No. _____

Registrar's No. **2983**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Bethesda Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME **Robert A. Rauch**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **486-16-4205**

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Catherine Rauch** 6. (c) Age of husband or wife if alive **37** years

7. Birth date of deceased **Feb. 22, 1893**
(Month) (Day) (Year)

8. AGE: Years **48** Months **1** Days **11** If less than one day hr. min.

9. Birthplace **Austria**
(City, town, or county) (State or foreign country)

10. Usual occupation **Office Clerk**

11. Industry or business **W.P.A.**

12. Name **Rudolph Rauch**

13. Birthplace **Austria**
(City, town, or county) (State or foreign country)

14. Maiden name **Ernestine**
(City, town, or county) (State or foreign country)

15. Birthplace **Austria**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Catherine Rauch**

(b) Address **8400 Evans Ave., Ferguson,**

17. (a) **Burial** (b) Date thereof **April 5, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cem.,**

18. (a) Signature of funeral director **Jos. W. Clark**

(b) Address **1125 Hodiament Ave.,**

19. (a) **APR - 4 1941** (b) **J. Bredack**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis**
(c) City or town **Ferguson, Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **Route 16, Box 580**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **4** day **3**
year **41** hour **2** minute **30** M.

21. I hereby certify that I attended the deceased from **4/3/41** to **4/3/41**
that I last saw him alive on **4/3/41** and that death occurred on the date and hour stated above.

Immediate cause of death _____

Respiratory failure

Due to **metastases of**

melano carcinoma

Due to **Primary site skin of**

right arm.

Other conditions (Include pregnancy within 3 months of death) **53**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature **J. Schergar** (M.D. or other) _____
Address **Bethesda Hosp.** Date signed **4/5/41**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....


Licensed Embalmer No. 3225.

P. O. Address 1125 Hodiament Ave.,

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 this body is not embalmed, fact should be so stated above.