

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

Registration District No. 784

Primary Registration District No. 111

Registrar's No. 791

1. PLACE OF DEATH: ST LOUIS COUNTY
 (a) County ST LOUIS COUNTY
 (b) City or town RICHMOND HTS MO
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: AT HOME
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 15 YEARS
 years, months or days

3. (a) PRINT FULL NAME SARAH RAFFERTY
 3. (b) If veteran, name war NONE
 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced WIDOWED
 6. (b) Name of husband or wife JAMES E. RAFFERTY
 6. (c) Age of husband or wife if alive DECEASED years
 7. Birth date of deceased Nov. 7 1869
 (Month) (Day) (Year)

8. AGE: Years 71 Months 7 Days 3
 If less than one day hr. _____ min. _____

9. Birthplace ST LOUIS MO
 (City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business _____
 12. Name Mrs J WYNN
 13. Birthplace BALTIMORE MD
 (City, town, or county) (State or foreign country)
 14. Maiden name MARY BEISCHER
 15. Birthplace UNKNOWN
 (City, town, or county) (State or foreign country)

16. (a) Informant Patricia Rafferty
 (b) Address 7415 Hiawatha

17. (a) BURIAL (b) Date thereof 4/14/41
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation SALVARY CEMETERY

18. (a) Signature of funeral director Walter Bopple
 (b) Address 6536 Clayton Rd

19. (a) APR 12 1941 (b) ffw
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Louis
 (c) City or town Richmond Heights
 (If outside city or town limits, write "RURAL")
 (d) Street No. 7415 Hiawatha
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 10th
 year 1941 hour 8:15 minute AM
 21. I hereby certify that I attended the deceased from Jan-19-
1938 to April 10 1941;
 that I last saw her alive on April 10 1941
 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion + hta

Due to _____
 Due to Hypertension
 Other conditions HTA
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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?

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature Arthur W. Westrup (M. D.)
 Address Wichita Grove Mo Date signed 4-12-41

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.....

390 Wm Rogers

..... Licensed Embalmer No.....

3905-

P. O. Address.....

Richmond 7420 2nd

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15863

Registration District No. 784

Primary Registration District No. 111

Registrar's No. 791

1. PLACE OF DEATH:

- (a) Country St. Louis
- (b) City or town Richmond Mo
(If outside city or town limits, write "RURAL" and name of township)
- (c) Name of hospital or institution:

(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 Sarah Rafferty

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F

5. Color or race w

6. (a) Single, widowed, married, divorced und

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased Nov 7 1869
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>5</u>	<u>3</u>	hr min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 9-21-61 (b) Thomas M. [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 10
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death: _____

Duration

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Arthur W. [Signature] (M.D. or other) _____
Address Weber's Brown Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

S-15855