

FILED MAR 30 1943

Registration District No. ....

Primary Registration District No. ....

1003

Registrar's No. 2640

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

1. PLACE OF DEATH:

(a) County.....  
(b) City or town.....  
(c) Name of hospital or institution:  
(d) Length of stay: In hospital or institution.....  
In this community.....

3. (a) PRINT FULL NAME MATTIA RASCH

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 MARRIED  
6. (b) Name of husband or wife HERMAN RASCH  
6. (c) Age of husband or wife if alive 63 years  
7. Birth date of deceased JULY-26-1883

8. AGE: Years 59 Months 7 Days 21  
If less than one day hr. min.

9. Birthplace PEORIA ILLINOIS

10. Usual occupation HOUSE WORK

11. Industry or business HOME

12. Name ADOLPH J. RASCH  
13. Birthplace GERMANY  
14. Maiden name LENA SCHMIDT  
15. Birthplace GERMANY

16. (a) Informant Ruth Joyce  
(b) Address 2331 Mulholland St.  
17. (a) BURIAL (b) Date there B-20-43  
(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director  
(b) Address  
19. (a) MAR 19 1943 (b) J. D. ...

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County 000  
(c) City or town ST. LOUIS 17 3  
(d) Street No. 2521A SOUTH THIRD STR. 92  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country No Attending Physician

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 18  
year 1943 hour 7 minute A.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  
Portine Hemorrhage  
Due to  
Due to  
Other conditions  
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?  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? No (Specify type of place)  
(e) Means of injury  
23. Signature Thomas F. Callahan (M. D. or other)  
Address Deputy Coroner Date signed 3-19-43

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**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 Clement McNeary

Licensed Embalmer No. 3733

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