

FILED APR 6 1945

State File No. ....

Registration District No. ....

Primary Registration District No. **1003**

Registrar's No. **2679**

1. PLACE OF DEATH: **318**

(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:  
**4911 Wabada Ave.**  
(If not in hospital or institution, write street number or location) **1**  
(d) Length of stay: In hospital or institution.....  
(Specify whether  
In this community **Life**  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**  
(c) City or town **St. Louis** **17**  
(If outside city or town limits, write "RURAL") **9** **6**  
(d) Street No. **4911 Wabada Ave.**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME

**Albert G. Ratz**

3. (b) If veteran, name war. **No**

3. (c) Social Security No. **None**

4. Sex **Male** (1) 5. Color or race **White** 6. (a) Single, widowed, married, divorced. **Married**  
6. (b) Name of husband or wife. **Adelaide Ratz** 6. (c) Age of husband or wife if alive. **69** years  
7. Birth date of deceased **December 26, 1872**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**72** **2** **25** hr. min.

9. Birthplace **St. Louis, Missouri** 0  
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired -**

11. Industry or business

MOTHER FATHER { 12. Name **Jacob Ratz**  
13. Birthplace **Germany** **4**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Wulfrath**  
15. Birthplace **Germany** **11**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Adelaide Ratz**  
(b) Address **4911 Wabada Ave.**

17. (a) **Entombment** (b) Date thereof **Mar. 24, 1945.**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Cal. Bone Mausoleum**

18. (a) Signature of funeral director **Calvin F. Feutz Funeral Home**  
(b) Address **4828 Natural Bridge Blvd.**

19. (a) **MAR 24 1945** (b) **J. F. Bedelick**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **21**,  
year **1945** hour **11:30** minute **A.** M.

21. I hereby certify that I attended the deceased from **Aug 1**  
**1929** to **March 21, 1945**  
that I last saw him alive on **March 20, 1945**  
and that death occurred on the date and hour stated above.

Immediate cause of death  
**Coronary Thrombosis XX**  
**Due to** **Arterial Hypertension 10 yrs**  
**Arterial Sclerosis 15 yrs**  
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 **J. F. Bedelick** (M. D. or other) **MD**  
Address **38331 Washington** Date signed **3/24/45**

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 John A. Melnar  
Licensed Embalmer No. 4186  
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 this body is not embalmed, fact should be so stated above.