

S. No. 2
FORM-5-43
Rev. 5-17-39
I X36871

FILED AUG 28 1946
Registration District No. **318**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County Illinois

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Vahlmanor 5904 Eastview 3
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community since January 6/46 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Madison 999

(c) City or town Granite City 11
(If outside city or town limits, write "RURAL")

(d) Street No. Rural (If rural, give location) N.R. 2

(e) Citizen of foreign country? no (Yes or No) 2
If yes, name country _____

3. (a) PRINT FULL NAME LOUISE RATH

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 Widowed 2

6. (b) Name of husband or wife Henry Rath

6. (c) Age of husband or wife if alive ✓ years _____

7. Birth date of deceased July 28 1863
(Month) (Day) (Year)

8. AGE: Years 83 Months 0 Days 12
If less than one day _____ hr _____ min.

9. Birthplace Namooki, Illinois Madison Co Illinois 1
(City, town, or county) (State or foreign country)

10. Usual occupation Home

11. Industry or business _____

MOTHER FATHER

12. Name Wm Allers

13. Birthplace Germany 4 4
(City, town, or county) (State or foreign country)

14. Maiden name Mahelmina Dubaud

15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Aug Rath

(b) Address R.R. 2 Granite City Ill

17. (a) Removal (b) Date thereof Aug 12 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Johns Cemetery Granite City Ill

18. (a) Signature of funeral director Ed. Schildham

(b) Address 2801 Madison Granite City Ill

19. (a) AUG 12 1946 (b) J. F. Bredeek
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 10 year 46 hour 7 PM minute 10 M.

21. I hereby certify that I attended the deceased from March 10 1946 to Aug 10 1946
Aug 5 1946
that I last saw her alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage.

Due to hypertension

Due to _____

Other conditions hypertension of age
(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 Peter A. Eck (M. D. or other) _____
Address 4701 St. Louis Ave Date signed 8/12/46

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

17
9
27830

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.....

J. Allen Davis Jr.
Licensed Embalmer No. *4053*

P. O. Address.....

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.