

S. No. 2  
M-5-43  
5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JAN 19 1947

UNITED STATES BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3013  
495

State File No. ....  
Registrar's No. ....

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County **St. Louis, Missouri**  
(b) City or town **St. Louis**  
(c) Name of hospital or institution: **St. Louis City Hospital - Max C. Starkloff Memorial**  
(d) Length of stay: **5 days**  
In this community **5 days**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **St. Louis**  
(c) City or town **St. Louis**  
(d) Street No. **3619a Cleon Memorial**  
(e) Citizen of foreign country? **No**  
If yes, name country .....

3. (a) PRINT FULL NAME **CHRISTINE RAUSCH**  
(b) If veteran, name war **----**  
(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 **Louis**  
6. (c) Age of husband or wife if alive **1874** years  
7. Birth date of deceased **August 22nd, 1874**

8. AGE: Years **72** Months **4** Days **22**  
If less than one day **hr. min.**

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

10. Usual occupation **home**

11. Industry or business .....

MOTHER FATHER { 12. Name **Valentine Schmidt**  
13. Birthplace **Germany**  
(City, town, or county) (State or foreign country)

14. Maiden name **Rose Binder**

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

16. (a) Informant **Rose M. Fabick**  
(b) Address **6145 Marwinette, St. Louis, Mo**

17. (a) **burial** (b) Date thereof **Jan. 17, '47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New St. Marcus Cemetery**

18. (a) Signature of funeral director **Wacker, J. F. Bredon**  
(b) Address **3634 Gravois, St. Louis, Mo.**

19. (a) **JAN 16 1947** (b) **J. F. Bredon**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Jan.** day **14th**  
year **1947** hour **11:05** minute **AM**

21. I hereby certify that I attended the deceased from **1-9-47**, 19... to **1/14/47**, 19...  
that I last saw her **or** alive on **1/14/47**, 19...  
and that death occurred on the date and hour stated above.

Immediate cause of death **Arteriosclerotic heart disease**  
Due to **Arteriosclerotic heart disease ? years**

Due to .....

Other conditions **9/3**  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations .....

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 **John J. ...** (Specify type of place) Means of injury **...**  
23. Signature **John J. ...** (M.D. or other) Date signed **1/14/47**  
Address .....

Duration **2 weeks**  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

*mail*

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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..... *Robert C. White* .....

Licensed Embalmer No. *2178* .....

P. O. Address *Albany 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.**