

S. No. 2
1-12-45
5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 28 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15383
Registrar's No. 900-

Registration District No. 317

Primary Registration District No. 6076

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Spanish Lake
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Talismann Lane Rt 4, Baden Station
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community Since Birth (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Louis
(c) City or town Spanish Lake
(If outside city or town limits, write "RURAL")
(d) Street No. Talismann Lane
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME GEORGE RAU
3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife Sophia (nee Warnecke)
6. (c) Age of husband or wife if alive Deceased
7. Birth date of deceased Nov. 12, 1862
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 5 5 hr. min.

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

10. Usual occupation Retired

11. Industry or business
12. Name Not Known
13. Birthplace Not Known
(City, town, or county) (State or foreign country)
14. Maiden name Not Known
15. Birthplace Not Known
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Walter Fittge
(b) Address Baden Station RT. 4

17. (a) Burial (b) Date thereof 4/21/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Salem Cemetery Black

18. (a) Signature of funeral director Math. Hermann & Son
(b) Address 2161 East Fair Avenue

19. (a) 4-22-47 (b) Coyle G. Shapiro
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 17
year 1947 hour 11:00 P.M.
21. I hereby certify that I attended the deceased from 5/25
1946 to 4/17 1947
that I last saw him alive on 4/17 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho pneumonia 5 days
Due to Arteriosclerosis, generalized 20 yrs.
Chronic nephritis 10 yrs.
Chronic myocarditis 8 yrs.
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: None
Of operations _____
Of autopsy None
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?
Jack, Mo.

While at work? _____
(Specify type of place) (c) Means of injury _____
23. Signature M. D. Johnson (M. D. Registrar) MO
Address Ferguson Mo Date signed 4/18/47

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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 William G. Buchhe

Licensed Embalmer No. 2110

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.