

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

14564
State File No. 3872
Registrar's No.

FILED APR 30 1948 818
Registration District No.

Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
7322 Virginia
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Frank Rahier

3. (b) If veteran, name war no

3. (c) Social Security No. 497-07-1323

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Elizabeth Rahier

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased September 20, 1871
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

76 7 1 hr. _____ min.

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

10. Usual occupation none

11. Industry or business unemployed

MOTHER FATHER { 12. Name Paschal Rahier

{ 13. Birthplace Belgium
(City, town, or county) (State or foreign country)

{ 14. Maiden name ???? Rahier

{ 15. Birthplace France
(City, town, or county) (State or foreign country)

16. (a) Informant Elizabeth Rahier

(b) Address 7322 Virginia Ave.

17. (a) burial (b) Date thereof 4/26/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Olive cemetery

18. (a) Signature of funeral director Fendler Und. Co.

(b) Address 7420 Michigan Ave.

19. (a) APR 24 1948 (Date received local registrar)

J. F. Breneck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County soo

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 7322 Virginia Ave. 9
(If rural, give location) 0

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 21
year 1948 hour 2 minute P. M.

21. I hereby certify that I attended the deceased from 16 June
1948 to 22 June, 1948
that I last saw h_____ alive on 16 June
and that death occurred on the date and hour stated above.

Immediate cause of death Arterio Sclerosis
heart disease

Duration 4 to 5 min

Due to _____

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)

(c) Means of injury _____

23. Signature A. F. Colman (M.D. or other)

Address 2715 Clifton Date signed 23 April

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 W E Morris

Licensed Embalmer No. 3360

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.