

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **20606**Registration District No. **336** Primary Registration District No. **6075** Registrar's No. **189**

1. PLACE OF DEATH:

- (a) County St. Francois
 (b) City or town Farminston RURAL St. Francois
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Missouri State Hospital No. 4 2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 yrs. 5 mos. 14
 (Specify whether

In this community _____
years, months or days)3. (a) PRINT FULL NAME FREDERICK NIELSEN RASMUSSEN3. (b) If veteran, name war Unknown 3. (c) Social Security No. Unknown4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased November 21, 1895
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
52 4 29 hr. min.9. Birthplace St. Louis County, Missouri
(City, town, or county) (State or foreign country)10. Usual occupation None

11. Industry or business _____

12. Name Peter Rasmussen 13. Birthplace Unknown Denmark
(City, town, or county) (State or foreign country)14. Maiden name Marie Nielsen 15. Birthplace Unknown Denmark
(City, town, or county) (State or foreign country)16. (a) Informant Records State Hospital No. 4
(b) Address Farminston, Missouri17. (a) Burial (b) Date thereof 4-22-48
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Oak Hill Cem., Kirkwood, Mo.18. (a) Signature of funeral director Parker Undertaking Co.
(b) Address Webster Groves, Missouri19. (a) 6-16-48 (b) Esther Rudloff
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County St. Louis
 (c) City or town Webster Groves
 (If outside city or town limits, write "RURAL")
 (d) Street No. 101 Selma
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20,
year 1948 hour 3 minute 45 P. M.21. I hereby certify that I attended the deceased from
Nov. 1, 1946, 19____, to April 20, 1948, 19____,
that I last saw him alive on April 20, 1948, 19____,
and that death occurred on the date and hour stated above.Immediate cause of death Lobar pneumonia, terminal

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Psychosis with epilepsyMajor findings: _____
Of operations _____Of autopsy No autopsy.

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? _____
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature John P. Brennan M.D. (Physician's signature)
State Hwy #4 Farmington (Address)
4/24/48 (Date)

Duration

PHYSICIAN

Underline
the cause of
which death
should be
charged sta-
tistically.

RECEIVED

District Health Officer No. 4
District File Number 648-7
Date Filed 6-22-4

MAR 21 1958

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 E. L. Aldrich

Licensed Embalmer No. 1332

P. O. Address Webster Groves

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.