

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 21254
Registrar's No. 5929

FILED JUL 15 1948

Registration District No. 318

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Baptist Hosp.
(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 Raymond G. Recker

3. (b) If veteran, name war _____ 3. (c) Social Security No. 497-01-0416

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Rose Eckelkamp Recker 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased: August 1 1891
(Month) (Day) (Year)

8. AGE: Years 56 Months 10 Days 0 If less than one day hr. _____ min. _____

9: Birthplace York Pennsylvania
(City, town, or county) (State or foreign country)

10. Usual occupation Auto Mechanic

11. Industry or business _____

12. Name John Recker

13. Birthplace York Pennsylvania
(City, town, or county) (State or foreign country)

14. Maiden name Josephine Hartung

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

16. (a) Informant Rose Recker

(b) Address 5848 Etzel Ave.

17. (a) Burial (b) Date thereof 7/6/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles Cem.

18. (a) Signature of funeral director Stroot-Carroll

(b) Address 4600 Natural Bridge Ave.

19. (a) JUL 2 1948 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 603
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 5848 Etzel 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 July day 1
1948 year hour 4 minute 40 P. M.

21. I hereby certify that I attended the deceased from Aug 24 July 1 1948
to July 1 1948
that I last saw him alive on July 1 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration _____

Due to Hypertension

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of 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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. P. ... M. D. or other _____
Address 15049 Delmar Date signed July 6 1948

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

300
47
39
908

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.....

.....
working under my personal supervision.

Registered Apprentice No.....

Signed *E. M. Hoffman*.....

Licensed Embalmer No. *1166*.....

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.