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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 22 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24635**
Registrar's No. **6112**

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

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

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital—Max C. Starkloff
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 0
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5703 Highland Memorial
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William H. Raphael
(b) If veteran, name war No
(c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month July day 7th
year 1948 hour 8 minut 20 P. M.
21. I hereby certify that I attended the deceased from 7/5/48
_____, 19____, to July 7th, 1948
that I last saw him alive on July 7th, 1948
and that death occurred on the date and hour stated above.

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced, Widower
6. (b) Name of husband or wife Rose Raphael
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased August 12 1874
(Month) (Day) (Year)

Immediate cause of death
Infarctus ventriculi h. coronariae 2 days
Due to Arteriosclerosis and Hypertension
Due to _____
Other conditions: _____
(Include pregnancy within 3 months of death)

8. AGE: Years 73 Months 10 Days 25
If less than one day hr. _____ min. _____

Physician
Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

9. Birthplace: Grand Island Nebraska
(City, town, or county) (State or foreign country)

10. Usual occupation Painter

11. Industry or business _____

12. Name Joseph Raphael

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

14. Maiden name Maria Louise Whitney
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Pete Perrera
(b) Address 4109 McPherson

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-10-48
(Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Cemetery

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) JUL 9 1948 (Date received local registrar) J. F. Bradese (Registrar's signature)

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 William M. Renden M.D. (City or town) (County) (State)
23. Signature 1515 Lafayette 7/8/48 (or other) _____
Address _____ Date signed _____

A

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.....

Albert G. Hoppe
2971

..... Licensed Embalmer No.....

..... 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.