

FILED AUG 23 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 518

Primary Registration District No. 1003

Registrar's No. 7048

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

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:
4343 Wallace
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____

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

(d) Street No. 4343 Wallace Ave.
(If rural, give location)

(e) Citizen of foreign country? 15 (Yes or No) _____
If yes, name country _____

3. (a) PRINT FULL NAME Joseph R Raybrook

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 9
year 1948 hour 4 minute _____ P. M.

21. I hereby certify that I attended the deceased from April 23
1948 to July 9 1948
that I last saw him alive on July 30 1948
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife Lillian B

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased: Mar 29 1888
(Month) (Day) (Year)

Immediate cause of death:
Cerebral aneurysm of middle
brain with metastasis
liver & peritoneum

Due to _____

Due to _____

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

8. AGE: Years 60 Months 4 Days 10 If less than one day _____ hr. _____ min.

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

Major findings:
Of operations As above

Of autopsy _____

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

10. Usual occupation Watchman

11. Industry or business _____

MOTHER FATHER { 12. Name Amandus Raybrook

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

{ 14. Maiden name Mary Goethlas

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

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 19

23. Signature [Signature] (M. D. _____)
Address [Address] Date signed [Date]

16. (a) Informant Lillian B Raybrook

(b) Address 4343 Wallace

17. (a) Burial (b) Date thereof 8/12/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation N Athens, Ill.

18. (a) Signature of funeral director J L Ziegenhein & Sons

(b) Address 7029 Gravois Ave.

19. (a) AUG 11 1948 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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. G. Peterson*

Licensed Embalmer No. *3767*

P. O. Address *7027 Gravois*

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.