

FILED NOV 9 1948

Registration District No. 27

Primary Registration District No. 4067

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
414 N. Florissant Rd.
(If not in hospital or institution, write street number or location)

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

In this community Life
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

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

(d) Street No. 414 N. Florissant Rd.
(If rural, give location)

(e) Citizen of foreign country? --- (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Federick Rascher

3. (b) If veteran, name war ---

3. (c) Social Security No. ---

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife Emma Rascher

6. (c) Age of husband or wife if alive Dec'd years

7. Birth date of deceased Sept. 28 1859
(Month) (Day) (Year)

8. AGE: Years 89 Months 0 Days 21

If less than one day
hr. _____ min. _____

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

10. Usual occupation Retired Lithographer

11. Industry or business ---

12. Name Federick Rascher 4

13. Birthplace Germany 1
(City, town, or county) (State or foreign country)

14. Maiden name Unknown Hurst 1

15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Edna Rascher

(b) Address Ferguson, Missouri.

17. (a) Burial (b) Date thereof 10/23/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. John's Cemetery

18. (a) Signature of funeral director White Funeral Home

(b) Address Ferguson, Missouri

19. (a) 10-22-48 (b) Carol A. Sharp
(Date received local registrar) (Registrar's signature) 655

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 20
year 1948 hour 6 minute 10A.M.

21. I hereby certify that I attended the deceased from 1947
19 47 to Oct 20 19 48
that I last saw him alive on 18 October 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary
Stem Myocardial
Failure

Due to Arteriosclerotic
Cardio-vascular renal disease

Due to 131

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? 0

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

23. Signature Joseph J. [Signature] (M. D. or other) 778
Address 94 N. [Signature] Date signed 10/22/48

Duration 10 days

Duration yrs.

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 L. M. White

Licensed Embalmer No. 3975

P. O. Address. Herguson, 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.