.S. No. 300
EV. 10.48

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

FILED AUG 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25203

State File No. 6492

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place): 50 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1547 So. 7th Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Ward 17
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 1547 So. 7th Street

3. NAME OF DECEASED (Type or Print)
a. (First): Margaret
b. (Middle): Reid
c. (Last): Rasker

4. DATE OF DEATH (Month) (Day) (Year): July 25 - 1949

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: August - 5 - 1880
9. AGE (In years last birthday): 68 — If under 1 year: Months: 11 Days: 20 — If under 24 hrs.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Black River, Missouri
12. CITIZEN OF WHAT COUNTRY?: U

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Albert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Albert Rasker — **ADDRESS**: 1547 So. 7th St

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Caranoma of stomach — INTERVAL BETWEEN ONSET AND DEATH: 4 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): none
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 151X

22. *I hereby certify that I attended the deceased from* April 10, 1949 *to* July 25, 1949, *that I last saw the deceased alive on* July 25, 1949 *and that death occurred at* 3:45 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John B Canepa M.D.
23b. ADDRESS: 2105 So Broadway
23c. DATE SIGNED: 7/26/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-28-49
24c. NAME OF CEMETERY OR CREMATORY: Mount Hope
24d. LOCATION (City, town, or county) (State): St. Louis County, Mo

DATE REC'D BY LOCAL REG.: JUL 27 1949
REGISTRAR'S SIGNATURE: J. B. Sasater
25. FUNERAL DIRECTOR'S SIGNATURE: Allen W McLaughlin — **ADDRESS**: 2301 Lafayette

(Licensed Embalmer's Statement on Reverse Side)

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 .....

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed C W Cooper

Licensed Embalmer No. 3633

P. O. Address 2301 Lafayette

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.