

FILED JAN 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42881

State File No. 10979
Registrar's No. 10979

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE _____ b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (In this place) 10-4-49	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		17
d. FULL NAME OF HOSPITAL OR INSTITUTION Infirmiry Hospital			d. STREET ADDRESS (If rural, give location) 4657 Cecil Place		
3. NAME OF DECEASED (Type or Print) a. (First) GORDON		b. (Middle) _____	c. (Last) RAUSS	4. DATE OF DEATH (Month) Dec (Day) 20 (Year) 1949	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH February 2 1883 66	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Planing Mill	11. BIRTHPLACE (State or foreign country) Herman Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A
13a. FATHER'S NAME Edward Rauss		13b. MOTHER'S MAIDEN NAME _____		14. NAME OF HUSBAND OR WIFE Ella Noll	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 496-22-6650	17. INFORMANT'S SIGNATURE OR NAME ADDRESS BAK Ella Noll 4657 Cecil Place			
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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 week 5 years	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis MO			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? HT 3 X			
22. I hereby certify that I attended the deceased from Oct 4, 1949 , to Dec 20 49 , that I last saw the deceased alive on Dec 20 , 19 49 , and that death occurred at 9:33p m., from the causes and on the date stated above.					
23a. SIGNATURE Oliver P. Krag, M.D. (Degree or title)			23b. ADDRESS 5600 Arsenal St., St. Louis		23c. DATE SIGNED 21 Dec 1949
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 23, 1949	24c. NAME OF CEMETERY OR CREMATORY New St. Marcus	24d. LOCATION (City, town, or county) (State) St. Louis MO		
DATE REC'D BY LOCAL REG. OFFICE DEC 22 1949	REGISTRAR'S SIGNATURE J. B. Sauter		FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. H. Herdumiller, Home		

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

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 Me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Elton W. Penelias

Licensed Embalmer No. 4283

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.

[Handwritten signature]