

FILED FEB 17 1950

STANDARD CERTIFICATE OF DEATH

State File No.

318

1003

1145

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		b. COUNTY 2209	
c. LENGTH OF STAY (in this place) 15 yrs		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital		d. STREET ADDRESS (If rural, give location) 20 - 2512 University St.	

3. NAME OF DECEASED (Type or Print) a. (First) Charles	b. (Middle)	c. (Last) Rahmoeller	4. DATE OF DEATH (Month) (Day) (Year) 2 4 50
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 3-13-1862	9. AGE (In years last birthday) (If under 1 year) (If under 24 hrs.) 87
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME William Rahmoeller	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE Christine Rahmoeller
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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. no	17. INFORMANT'S SIGNATURE OR NAME Cora Rahmoeller	ADDRESS 2512 University St
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Prostate		1 yr.
	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. Bilateral Pneumonia		7 days

19a. DATE OF OPERATION 2-50 7 hysterectomy	19b. MAJOR FINDINGS OF OPERATION Bleeding in Urinary Bladder. Suspected Carcinoma of Bladder	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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) 177X
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 4:00 PM 3-4-50	21e. INJURY OCCURRED WHILE AT WORK? () NOT WHILE AT WORK ()	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from **1-31**, 19**50**, to **2-4**, 19**50**, that I last saw the deceased alive on **2-4**, 19**50**, and that death occurred at **4 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H. L. Tomlinson M.D.	23b. ADDRESS 634 N. Grand	23c. DATE SIGNED 2-6-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 2-7-50	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo
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DATE REC'D BY LOCAL REG. FEB 6 1950	REGISTRAR'S SIGNATURE J. B. Sarater	25. FUNERAL DIRECTOR'S SIGNATURE Goodhart & Goodhart	ADDRESS AVE. 2228 St. Louis
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(Licensed Embalmer's Statement on Reverse Side)

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

working under my personal supervision.

Student Embalmer No.....

Signed.....

G. W. Wilkinson

Signed.....
Student Embalmer

Licensed Embalmer No. 3575

P. O. Address At Home

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.