

FILED DEC 12 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **38765****318**PRIMARY REG. DIST. NO. **1003**Registrar's No. **10628**

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 <b>Missouri</b> b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) township)		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>DePaul Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>4042A Natural Bridge Ave.</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>CLARA</b>			b. (Middle) <b>L.M.</b>		c. (Last) <b>RAHE</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 3-1955</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>		8. DATE OF BIRTH <b>Dec. 15-1883</b>		9. AGE (In years last birthday) <b>71</b> IF UNDER 1 YEAR Months Days IF UNDER 2 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.,</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Fred Wm. Rahe</b>			13b. MOTHER'S MAIDEN NAME <b>Lydia Stahlberg</b>			14. NAME OF HUSBAND OR WIFE			
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. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Herman Rahe 4042 A Natural Bridge Av.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <b>5 weeks.</b>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arterio sclerosis.</b>					
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				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 <b>331X</b>				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)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <b>Feb., 1955</b> , to <b>Dec., 1955</b> , that I last saw the deceased alive on <b>12/3, 1955</b> , and that death occurred at <b>11:30P m.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>Wm. O. Mowrey</b> (Degree or title) <b>William O. Mowrey M.D.</b>				23b. ADDRESS <b>3625 Fairview</b>			23c. DATE SIGNED <b>12/5/55</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Dec. 7-1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>			
DATE REC'D BY LOCAL REG. <b>DEC 5 1955</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Leidner Undertaking Co. 2223 St. Louis, Av</b>				

S.P. (Licensed Embalmer's Statement on Reverse Side)

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

300  
48

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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.....  
Signature of Student Embalmer

Signed..... *Paul A. Wach*.....

Licensed Embalmer No. *477*.....

P. O. Address..... *Howe*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.