

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046190

STATE FILE NUMBER

FILED JAN 5 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12222

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURY COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS.		c. CITY OR TOWN ST. LOUIS.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION FIRMIN DESLOGE 2246 # 231		d. STREET ADDRESS (If outside, give location) 2007 50 Broadway	
3. NAME OF DECEASED (Type or print) First Middle Last MAX. - RASFEL		4. DATE OF DEATH Month Day Year 12-17-1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-20-1892
9. AGE (In years . last birthday) 66		10. F UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) TAILOR		10b. KIND OF BUSINESS OR INDUSTRY SELF EMP.	
11. BIRTHPLACE (City and state or country) RUSSIA.		12. CITIZEN OF WHAT COUNTRY? 6 U.S.A	
13a. FATHER'S NAME NO KNOWN.		13b. MOTHER'S MAIDEN NAME NOT KNOWN	
14. NAME OF HUSBAND OR WIFE DECEASED			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) NO NO		16. SOCIAL SECURITY NO.	
17. INFORMANT VIOLET FEY		Address 3465 GASCONADE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hemorrhage DUE TO (b) Bilateral lobar pneumonia DUE TO (c) 490X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized arteriosclerosis mild-			INTERVAL BETWEEN ONSET AND DEATH 12 hours 4 days
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from December 4 th 1958 to December 17, 1958 last saw him alive on December 16, 1958 Death occurred at 2 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Augustine Jones, M.D.		22b. ADDRESS 634 North Grand St. 3rd	
22c. DATE SIGNED Dec. 18, 1958			
23a. BURIAL, CREMATION, EMBALM (Specify)		23b. DATE 12-20-1958	
23c. NAME OF CEMETERY OR CREMATORY ST. MATHEW CEM.		23d. LOCATION (City, town, or county) (State) ST. LOUIS MO	
24. GENERAL DIRECTOR Wm. J. Hermel		25. DATE RECD. BY LOCAL REG. DEC 18 '58	
ADDRESS 3819 do Grand		26. REGISTRAR'S SIGNATURE Carl Smith M.D. mjb	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

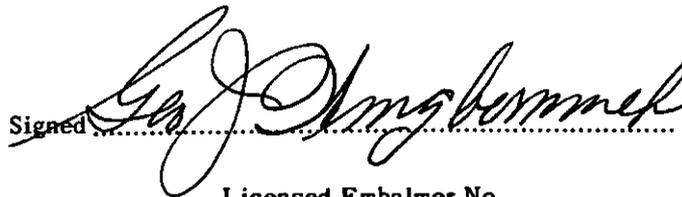
All diseases in Part I must be causally related.

300
1-57

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 

Licensed Embalmer No.....
P. O. Address

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.