

VS JAN 16 1961

318

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133-61-008559

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF
 ITEM NO.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis, Missouri		c. CITY OR TOWN St. Charles, Mo.	
c. FULL NAME OF (IF NOT in hospital, give location) St. Louis Children's		d. STREET ADDRESS (If outside, give location) 3033 Ridgeview Drive	
3. NAME OF DECEASED (Type or print) Margaret Ann Rauch		4. DATE OF DEATH 1-5-1961	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-24-60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) St. Charles, Mo.
13a. FATHER'S NAME Robert Peter Rauch		14. NAME OF HUSBAND OR WIFE Single	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Address Alice Trowbridge, 500 S. Kingshighway	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO (b) <u>Congenital leukemia (lymphatic)</u> DUE TO (c) <u>204.0</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	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 _____ s.m. _____ p.m. _____ Month, Day, Year _____		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
20d. INJURY OCCURRED WHILE AT WORK <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.)	
21. I attended the deceased from <u>1-4-61</u> to <u>1-5-61</u> and last saw her/him alive on <u>1-5-61</u> Death occurred at <u>3:05 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Eugenia M. Pearce, MD</u>		22b. ADDRESS 500 S. Kingshighway	
22c. DATE SIGNED 1-5-61		23c. NAME OF CEMETERY OR CREMATORY St. Charles Borromeo Cemetery	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23d. LOCATION (City, town, or county) (State) St. Charles, Missouri	
23b. DATE 1-7-1961		23d. LOCATION (City, town, or county) (State) St. Charles, Missouri	
24. FUNERAL DIRECTOR <u>D. C. Allmonroe & Son, 44 Cherry</u>		25. DATE RECD. BY LOCAL REG. JAN 5 1961	
26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>		26. REGISTRAR'S SIGNATURE	

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

James R. Amaleng

Licensed Embalmer No. 4832

P. O. Address St. Charles

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.