

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-007198

AMENDED FILED VS FEB 20 1961 Registration District No. 317 Primary Registration District No. 500 Registrar's No. 305 STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LEFFON</u>		Length of stay in Ib <u>10 days</u>	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mennings Nursing Home</u>			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4651 Cecil Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Matilda</u> Middle <u>Rahn</u> Last			4. DATE OF DEATH Month <u>Jan.</u> Day <u>29</u> Year <u>1961</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/7/76</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u>9</u> Days <u>22</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Red Bud, Ill</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Henry Wegener</u>		13b. MOTHER'S MAIDEN NAME <u>Caroline Rosenberg</u>		14. NAME OF HUSBAND OR WIFE <u>Wendell Rahn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>xxx xx</u>	17. INFORMANT <u>Emma Rahn</u>	Address <u>4651 Cecil Pl St. Louis</u>	
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>cerebral thrombosis, recurrent</u> DUE TO (b) <u>cerebral arteriosclerosis -</u> DUE TO (c) <u>arteriosclerosis, generalized.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Aspiration pneumonia: A.S.H.P.</u>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	20b. SUICIDE <input type="checkbox"/>	20c. 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 a.m. p.m.	Month, Day, Year				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>Jan 24, 1961</u> to <u>Jan 29, 1961</u> and last saw her <u>Jan. 28, 1961</u> alive on Death occurred at <u>2:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Hugh P. Cravel, M.D.</u>			22b. ADDRESS <u>9764 Teason Ferry Rd</u>		22c. DATE SIGNED <u>1/31/61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb, 1 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Lutheran</u>	23d. LOCATION (City, town, or county) (State) <u>Red Bud, Ill.</u>		
24. FUNERAL DIRECTOR <u>Koch Funeral Home Red Bud, Ill.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>1-31-61</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>	

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 Not embalmed Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Richard Koch*

Licensed Embalmer No. 7064 Illinois

P. O. Address Red Bud, Ill.

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.