

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Clark Co Mo

Township Wash Wyaconda

Registration District No. 194

File No. 12854

Village _____

Primary Registration District No. 4117

Registered No. _____

City Wyaconda (NO. _____)

St. _____ Ward _____

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME George Blunt Rohrbungh

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE married
MARRIED WIDOWED OR DIVORCED (If write the word)

DATE OF BIRTH June 20, 1850
(Month) (Day) (Year)

AGE 61 yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Peddler
(b) General nature of industry, business, or establishment in which employed (or employer) H-11

BIRTHPLACE (City or town, State or foreign country) West Virginia

NAME OF FATHER George Rohrbungh

BIRTHPLACE OF FATHER (City or town, State or foreign country) West Virginia

MAIDEN NAME OF MOTHER Don't know

BIRTHPLACE OF MOTHER (City or town, State or foreign country) West Virginia

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Rohrbungh

(ADDRESS) _____
Filed April 24 1924 REGISTRAR J. B. ...

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 4th, 1924
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

By accident killed instantly

207M (Duration) _____ yrs. _____ mo. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.

(Stated) _____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Keper Mo DATE OF BURIAL May 5, 1924

UNDERTAKER Frank Gosh ADDRESS Wyaconda Mo

N. H. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

County _____
 Township _____
 or
 Village _____
 or
 City _____ (NO. _____)

Registration District No. _____

File No. _____

Primary Registration District No. _____

Registered No. _____

St. _____ Ward _____

(If death occurred in hospital or institution give its NAME instead of street and number)

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (If <i>rit</i> the word)
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	
AGE	_____ yrs. _____ mos. _____ ds.	IF LESS than 1 day _____ hrs. or _____ min.?
OCCUPATION	(a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____	

BIRTHPLACE (City or town, State or foreign country)	NAME OF FATHER
BIRTHPLACE OF FATHER (City or town, State or foreign country)	BIRTHPLACE OF MOTHER (City or town, State or foreign country)
THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) _____	
(ADDRESS) _____	

Filed _____, 191____, REGISTRAR

**MISSOURI STATE BOARD OF HEALTH
 BUREAU OF VITAL STATISTICS
 CERTIFICATE OF DEATH**

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____, 191____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

Contributory
 (SECONDARY)

(Signed) _____ (Duration) _____ yrs. _____ mos. _____ ds.
 _____ (Duration) _____ yrs. _____ mos. _____ ds.
 _____ (Address) _____ M. D.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.
 Where was disease contracted if not at place of death? _____
 Former or usual residence _____

PLACE OF BURIAL OR REMOVAL _____ **DATE OF BURIAL** _____, 191____

UNDERTAKER _____ **ADDRESS** _____

*Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MS should state

PLACE OF DEATH

County Clark Co Mo.
Township Wyaconda
Village _____
or _____
City Wyaconda (NO. _____) St.: _____ Ward) _____

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 194 File No. 12854
Primary Registration District No. 4117 Registered No. _____

FULL NAME George Blend Rohlsauger

[If death occurred in a hospital or institution, give the NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

SEX m COLOR OR RACE w SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) m

DATE OF BIRTH June 20 1885
(Month) (Day) (Year)

AGE 61 yrs. mos. ds. IF LESS than 1 day, hrs. or min.

OCCUPATION (a) Trade, profession, or particular kind of work Peddler
(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) W. Va.

PARENTS
NAME OF FATHER George Rohlsauger
BIRTHPLACE OF FATHER W. Va.
MAIDEN NAME OF MOTHER Shirley
BIRTHPLACE OF MOTHER W. Va.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X His son
(ADDRESS) X Govin Mo

Filed 6/7/19 1917 JAS wearingen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH May 3 1917
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 1917, to _____, 1917, that I last saw him alive on _____, 1917, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:
R. P. President Keller instantly
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) _____ (Duration) _____ yrs. _____ mos. _____ ds.
(Signed) J. A. Swearingen M. D.
May 3, 1917 (Address) Wyaconda Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death _____ yrs. _____ mos. _____ ds. in the State _____ yrs. _____ mos. _____ ds.
Where was disease contracted if not at place of death? _____
Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Keoper Mo. DATE OF BURIAL May 5, 1917

UNDERTAKER Jed Herch ADDRESS Wyaconda Mo

Original file, date May 3, 1917 All information called for must be written on this Supplementary Certificate.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (lived, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible, to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)