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

N. B.—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.

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

File No. 11291

Registration District No. 592

Primary Registration District No. 4359

Registered No. 17

PLACE OF DEATH

County Montgomery

Township

or Village

or City Montgomery (NO. St.; Ward)

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

FULL NAME Emil Rosenpuger

PERSONAL AND STATISTICAL PARTICULARS

SEX: M

COLOR OR RACE: W

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

DATE OF BIRTH: April (Month) 29 (Day), 1831 (Year)

AGE: 84 yrs. 10 mo. 19 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Sawyers 82
(b) General nature of industry, business, or establishment in which employed (or employer): 97

BIRTHPLACE (City or town, State or foreign country): Gerlustadt Germany

PARENTS

NAME OF FATHER: Julius Rosenpuger

BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany

MAIDEN NAME OF MOTHER: Catharina Rincus

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Frankenthal Ger

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. S. Rosenpuger Jr.

(ADDRESS) Montgomery Mo

Filed Mar 19, 1916. E. W. Tinsley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Mar (Month) 18 (Day), 1916 (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. 1, 1916, to Mch. 18, 1916, that I last saw him alive on Mch. 18, 1916, and that death occurred, on the date stated above, at 9 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,

Chronic Arterio Sclerosis

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) David T. Morton M. D.

Mch. 19 1916 (Address) Montgomery City 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: High Hill Cemetery

DATE OF BURIAL: 3/20 1916

UNDERTAKER: C. W. Stephens

ADDRESS: Montgomery Mo

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

PLACE OF DEATH

County .....

Township ..... or Village ..... or City ..... (NO. ..... St.: ..... Ward)

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

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

FULL NAME .....

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

N. B.—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.

PERSONAL AND STATISTICAL PARTICULARS

SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH ....., 1..... (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)

PARENTS
- NAME OF FATHER
- BIRTHPLACE OF FATHER (City or town, State or foreign country)
- MAIDEN NAME OF MOTHER
- 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

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH ....., 191... (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:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory ..... (SECONDARY)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 191... (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 | DATE OF BURIAL ....., 191...

UNDERTAKER | ADDRESS