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

Do not use this space.

8906

MAY 28 1927

1. PLACE OF DEATH

County: Marion — Registration District No.: 547 — File No.:

Township: Marion — Primary Registration District No.: 3099 — Registered No.: 99

City: Hannibal (No. 420 North Fourth St.; 1 Ward)

2. FULL NAME: Gertrude Rauscher

(a) Residence. No. 420 North Fourth St., 1 Ward. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U.S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Chas. G. Rauscher

6. DATE OF BIRTH (MONTH, DAY AND YEAR): April 13 - 1841

7. AGE: Years 85; Months 11; Days 18; If less than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): " "

(c) Name of employer: " "

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Germany

PARENTS

10. NAME OF FATHER: Henry Stecher

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Germany

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Germany

14. INFORMANT: Chas. Rasson (Address): Hannibal Mo.

15. FILED: 4/1, 1927 — C. E. Shrode, Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March 31 - 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 at, 1926, to March 31, 1927, that I last saw her alive on March 31, 1927, and that death occurred, on the date stated above, at 5 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arteria Sclerosis

97 [illegible]

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) [illegible], M. D.

4/1, 1927 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Riverside Cemetery — DATE OF BURIAL: 4/1 - 1927

20. UNDERTAKER: Schwab Funeral Home — ADDRESS: Hannibal

NOTE: 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.