

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

Do not use this space.

33104 ⁴⁵
23

File No. _____
Registered No. 254 St. _____ Ward _____

1. PLACE OF DEATH

County Cole Registration District No. 213
Township Jefferson Primary Registration District No. 3014
City Jefferson (No. _____)

2. FULL NAME

(a) Residence. No. La Rauschellach St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. mos. 18 da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Widow</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR)		
7. AGE	YEARS	MONTHS
	<u>69</u>	<u>5</u>
		DAYS
		<u>8</u>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>Farmer</u>		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 23 1928
17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1928, to Oct 23, 1928, that I last saw h. alive on Oct 7, 1928, and that death occurred, on the date stated above, at 11 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
cerebral hemorrhage
87
10/14/28 (duration) yrs. mos. 6 da.
CONTRIBUTORY Arterio Sclerosis
(SECONDARY)
High blood pressure (duration) yrs. mos. da.

9. BIRTHPLACE (CITY OR TOWN) Versailles
(STATE OR COUNTRY) Morgan

10. NAME OF FATHER Ferdinand Kauschellach

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

12. MAIDEN NAME OF MOTHER Sophia Bates

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

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH, _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) W.A. Clark, M. D.
10/23/28 (Address) Jefferson Mo
*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.

14. INFORMANT W.S. Rauschellach
(Address)

15. FILED 10-28-28 L. Bedford
REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Hope Hill Cem. DATE OF BURIAL Oct 25 1928
20. UNDERTAKER Richarda Kauschellach ADDRESS _____

1928
If 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.



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Osceola

Registration District No. 213

File No.

Township

Primary Registration District No. 3014

Registered No. 256

City Jefferson

(No.)

St. 1 Ward

2. FULL NAME

Leo Gauschelbach

(a) Residence. No. St. Ward.
(Usual place of abode) (if nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 15 - 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 5 8

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer) (duration) yrs. mos. ds.
(c) Name of employer

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.

INFORMANT (Address)

15.

FILED 10-28-28 Subredford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 23 1928

17. I HEREBY CERTIFY That I attended deceased from 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

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) M. D.

, 19 (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 DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. AGE should be stated EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. Exact statement of OCCUPATION is very important. Exact statement of OCCUPATION is very important. ALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-33310-4