

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

5175
 Do not use this space.

W. H. Maizner
 36 FEB 27 MAR 12 1939

1. PLACE OF DEATH
 (a) County..... / Registration District No.....
 (b) Township..... / Primary Registration District No..... Registered No. **1868**
 (c) or City..... **ST. LOUIS, MO.** (d) Street No. **ALEXIAN BROTHERS HOSPITAL** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *260* **JOHN ROTHENBUCHER**
 (a) Residence, No. **3625 OAK HILL** St. 16 (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **M.** **4. COLOR OR RACE** **W.** **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)** **SINGLE**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **JAN. 16, 1860**
7. AGE YEARS **79** MONTHS **1** DAYS **9** If LESS than 1 day,hrs. ormin.
OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **BREWERY WORKER**
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) **JAN. 1, 1924** **11. Total time (years) spent in this occupation**
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **ST. LOUIS, MO.**
FATHER
13. NAME **JOHN ROTHENBUCHER**
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **GERMANY**
MOTHER
15. MAIDEN NAME **MARGARET BASHE**
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **FRANCE**
17. INFORMANT (ADDRESS) *Geoff Hepper*
18. BURIAL, CREMATION, OR REMOVAL
 PLACE **OLD PICKER CEM.** DATE **2/28/39**
19. FUNERAL DIRECTOR (NAME) (ADDRESS) **OSCAR J. HOFFMEISTER**
4016 CHIPPEWA ST.
20. FILED **FEB 27 1939** *J. P. Bucher* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Feb. 25, 1939**
22. I HEREBY CERTIFY, That I attended deceased from **Feb. 21, 1939 to Feb. 25, 1939**
 I last saw him alive on **Feb. 25, 1939** Death is said to have occurred on the date stated above, at **11:30** m.
 The principal cause of death and related causes of importance were as follows:
coronary thrombosis
Ch. myocarditis
 Date of onset
 Name of operation *none* Date of
 What test confirmed diagnosis? *diagnosis* Was there an autopsy? *no*
23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? *none* Date of injury
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury *none*
 Nature of injury
24. Was disease or injury in any way related to occupation of deceased?
 If so, specify (Signed) *J. H. Doyne* M. D.
 (Address) *3606 KRAMER ST*

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Edmund H. Leisinger

Licensed Embalmer No. *4089*

P. O. Address *4016 Chippewa*

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 this body is not embalmed, above space should be left blank.