

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

20760  
Do not use this space.

791  
1008

1. PLACE OF DEATH

(a) County ..... Registration District No. ....  
(b) Township ..... Primary Registration District No. ....  
(c) City or St. Louis, Mo. ..... (d) Street No. .... City Sanitarium ..... 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 68 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. **5604**

2. PRINT FULL NAME Harry Rothan

(a) Residence, No. State Hospital #4 Farmington St. Mo. ..... (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Single  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) About 1871  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min. About 68

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Salesman  
9. Industry or business in which work was done, as saw mill, bank, etc. Travelling  
10. Date deceased last worked at this occupation (month and year) 1890 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) St. Louis (STATE OR COUNTRY) Missouri

FATHER  
13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Unknown

MOTHER  
15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) Unknown (STATE OR COUNTRY) Unknown

17. INFORMANT Walter Moore M. D. (ADDRESS) 5400 Arsenal St.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Swain DATE 6/27 1939

19. FUNERAL DIRECTOR (NAME) W. L. Moore (ADDRESS) 4356 Lindell

20. FILE JUN 26 1939 J. P. Brubaker Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 24, 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1938 to June 24, 1939  
I last saw h. im alive on June 24, 1939 19..... Death is said to have occurred on the date stated above, at 7:45 P. M.  
The principal cause of death and related causes of importance were as follows:

Chronic Nephritis ..... 5/10/39/x Date of onset

Other contributory causes of importance:  
Pyohydronephrosis ..... 5/10/39/x  
Cystitis with Bladder Stones ..... 5/10/39/x

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
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 .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....  
If so, specify .....  
(Signed) W. L. Moore M. D.  
(Address) 5400 Arsenal 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 Ray W Wilkerson

Licensed Embalmer No. 3575

P. O. Address.....

**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.**