

Registration District No. **136**

Primary Registration District No. **5194**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Carroll
 (b) City or town De Witt Rural
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2
(Specify whether)
 In this community _____
years, months or days

3. (a) PRINT FULL NAME CHARLEY RASCH

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race _____ 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased Feb. 26 1877
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>63</u>	<u>6</u>	<u>17</u>	hr. _____ min. _____

9. Birthplace Germany
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Fredrick Rasch

13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Wilhelmine Margwandt
(City, town, or county) (State or foreign country)

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Emma Bergman

(b) Address Habanda, Mo.

17. (a) Burial (b) Date thereof 9/14/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation De Witt, Mo.

18. (a) Signature of funeral director: Meyer Funeral Home

(b) Address Brunswick, Mo.

19. (a) Sept 14-40 (b) Alta Henderson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Carroll
 (c) City or town De Witt Rural
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 13th
 year 1940 hour 2 minute 25 A. M.

21. I hereby certify that I attended the deceased from 12th
Sept., 1940, to Sept 13, 1940
 that I last saw him alive on Sept 12th, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy Duration 1 Da

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 131

While at work? _____
(Specify type of place) (e) Means of injury

23. Signature H.A. Saults (M. D. or other) 1

Address De Witt Mo. Date signed 9-13-40

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.

07-8-97
POLICE
MAY 18 1997
MAY 18 1997
MAY 18 1997

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 John H. Meyer
Licensed Embalmer No. 37030
P. O. Address Brunswick

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31653-7

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 136

Primary Registration District No. 5194

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Newitt T.P.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Charley Rasch

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m (5. Color or race White) 6. (a) Single, widowed, married, divorced 8

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 63 Months 6 Days 17 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Feb 7-1941 (b) alta Henderson (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 13
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature H. A. Sauls (M. D. or other)

Address Newitt _____ Date signed _____

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

SUPPLEMENTARY

