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MAY 12 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

14482

State File No. \_\_\_\_\_

Registration District No. 303

Primary Registration District No. 5420

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:  
 (a) County. Gasconade  
 (b) City or town. Beauf Rural Roark Twp.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
9 mi. S. of Hermann, Mo  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution. \_\_\_\_\_  
 In this community. 50 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME. FRED A. ROTSCHAER  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife. Minnie Rotschaer  
 6. (c) Age of husband or wife if alive 76 years  
 7. Birth date of deceased. January 9 1858  
 (Month) (Day) (Year)

8. AGE: Years 83 Months 3 Days 10  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Phillip Rotschaer  
 13. Birthplace Germany  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Unknown Grote  
 15. Birthplace Germany  
 (City, town, or county) (State or foreign country)

16. (a) Informant Rev. J. A. Rotschaer  
 (b) Address Sibley, Iowa

17. (a) Burial (b) Date thereof April 21, 1941  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Drake Emmanuel Cem.  
Hugo H. Blumer

18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address Hermann, Missouri

19. (a) 4-21-41 (b) Anna K. Reichhoff  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County Gasconade  
 (c) City or town Hermann, Mo Rural  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 9 mi. S. of Hermann, Mo  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 18  
 year 1941 hour 8 minute 30 P.M.

21. I hereby certify that I attended the deceased from Apr 12, 1941, to Apr 18, 1941;  
 that I last saw him alive on Apr 18, 1941;  
 and that death occurred on the date and hour stated above.

Immediate cause of death  
Pneumonia  
of left side none  
of tubercular  
Also Hypertension  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

Major findings:  
 Of operations 6  
 Of autopsy 6

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

23. Signature John Engelhardt (M. D. or other) 0  
 Address Stauf Hill, Mo Date signed 4-20-41

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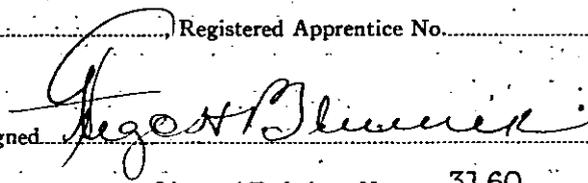
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

working under my personal supervision.

Registered Apprentice No.

Signed



Licensed Embalmer No. 3160

P.O. Address Hermann, Missouri

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, fact should be so stated above.

REC-108

MISSOURI STATE BOARD OF EMBALMERS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. 303

Primary Registration District No. 5420

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Dixon

(b) City or town Boark 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 \_\_\_\_\_  
years, months or days

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) Citizen of foreign country \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Fred A Rotschafner

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month Apr day 18  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ year

7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death resulted on the date and hour stated above.

8. AGE: Years Months Days If less than one day

83	3	10	_____ hr. _____ min.
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Immediate cause of death: Pneumonia (Dyspnea) Bronchial Pneumonia (left side NON-tubercular)

Due to: Also Hypertension

9. Birthplace: \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

11. Industry or business \_\_\_\_\_

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)

PHYSICIAN: \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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 John Engelbrecht (M. D. or other) \_\_\_\_\_  
Address Stang Hill Date signed 6-21-41

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

SUPPLEMENTAL

S-14482