DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 11 1942 747

Registration District No. _____

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5780

State File No. 3346

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County: Reynolds

(b) City or town: Rural: Black River Township
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3 miles north of Black
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) In this community: life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Reynolds

(c) City or town: rural
(If outside city or town limits, write "RURAL")

(d) Street No.: 3 miles North of Black
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME: Carylan Francis Rothlisberger

3. (b) If veteran, name war: #

3. (c) Social Security No.: #

4. Sex: fem

5. Color or race: white

6. (a) Single, widowed, married, divorced: single

6. (b) Name of husband or wife _____

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

7. Birth date of deceased: Dec. (Month) 5 (Day) 1941 (Year)

8. AGE: Years 0 Months 0 Days 23 If less than one day _____ hr. _____ min.

9. Birthplace: Black Mo. (City, town, or county) (State or foreign country)

10. Usual occupation: none

11. Industry or business _____

MOTHER FATHER

12. Name: Albert Rothlisberher

13. Birthplace: Black Mo. (City, town, or county) (State or foreign country)

14. Maiden name: Peachie Tilley

15. Birthplace: Ruble Mo. (City, town, or county) (State or foreign country)

16. (a) Informant: Albert Rothlisberger

(b) Address: Black Mo

17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 12-30-41 (Month) (Day) (Year)

(c) Place: burial or cremation: Black Mo.

18. (a) Signature of funeral director: Norman White & Sons

(b) Address: Ironton Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec day: 29 year: 1941 hour: 12: minute: 10 A. M.

21. I hereby certify that I attended the deceased from Dec. 28, 1941, to _____, 19____; that I last saw h. ev. alive on Dec. 28, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: hemorrhage	3 days
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 160 C	
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? _____

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

23. Signature: [illegible] (M. D. or other) M.D.

Address: Ironton, Mo. Date signed 12-29-41

1174

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 1422
Date Filed

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 was not embalmed, Registered Apprentice No. working under my personal supervision.

Signed Ernest J. White

Licensed Embalmer No. 3012

P. O. Address Winston Sa

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
(Rev.)—8-21-41
I X29288

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MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3346

Registration District No. 747 Primary Registration District No. 5980 Registrar's No.

1. PLACE OF DEATH:
(a) County Reynolds
(b) City or town 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 (Specify whether years, months or days)
In this community

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 Carylan H. Rothlisberger
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec (Month) 5 (Day) 1941 (Year)
8. AGE: Years — Months — Days 23 If less than one day hr. 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Mar 6th 1942 (Date received local registrar) (b) Mrs Tirza Wilkington (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 19 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY