

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
NOV 6 1944
128

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
2000

State File No. _____
Registrar's No. 814A

1. PLACE OF DEATH: GREENE
(a) County
(b) City or town Springfield
(c) Name of hospital or institution: Burge Hospital
(d) Length of stay: In hospital or institution 5 days 0
In this community 65 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County GREENE
(c) City or town Rural, SPRINGFIELD
(d) Street No. R. F. D. # 11
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Frank Rosenburger
(b) If veteran, name war NO
(c) Social Security No. NO

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 12
year 1944 hour 10 minute 30 P. M.
21. I hereby certify that I attended the deceased from Oct 6 1944 to Oct 12 1944
that I last saw him alive on Oct 12 and that death occurred on the date and hour stated above.

4. Sex male | 5. Color or race white | 6. (a) Single, widowed, married, divorced, married
(b) Name of husband or wife Della Rosenburger | 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased: July 28, 1871

Immediate cause of death: Cerebral Hemorrhage
Duration: 10 Days

8. AGE: Years 73 Months 2 Days 14
If less than one day hr. min.

Due to: arterial disease
Due to: _____
Other conditions: 830'
(Include pregnancy within 3 months of death)

9. Birthplace: Louisville Ky. 1
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.
Major findings: _____
Of operations: _____
Of autopsy: _____

10. Usual occupation: Farmer
11. Industry or business: Farming
12. Name: Joseph Rosenburger 5
13. Birthplace: Bern Switzerland
14. Maiden name: Phylla Irana Baker Switzerland
15. Birthplace: Bern Switzerland

16. (a) Informant: Sylvia Rosenburger
(b) Address: 1925 N. Rogers - Dept Sp 8 Ma

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

17. (a) Burial, cremation, or removal: Burial, Church
(b) Date thereof: Oct 15-44
(c) Place: burial or cremation: _____
18. (a) Signature of funeral director: _____
(b) Address: _____
19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
While at work? _____
23. Signature: _____ (M. D. or other) _____
Address: _____ Date signed: 10-13-44

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

629

39

784

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.....

Walter Rhodes

Licensed Embalmer No.....

4071

P. O. Address.....

Springfield

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.