. S. No. 2
OM—8-43
v. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

9174

State File No.

FILED MAR 22 1945

Registration District No. 4 Primary Registration District No. 1000 Registrar's No. 251

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St Joseph (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2505 St Joseph Ave (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community abt 41 yrs, years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan

(c) City or town St Joseph (If outside city or town limits, write "RURAL")

(d) Street No. 2505 St Joseph Ave (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME WILLIAM-HENRY-RAUCH.

3. (b) If veteran, name war No

3. (c) Social Security No. No.

4. Sex Male

5. Color or race Wht

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

6. (b) Name of husband or wife Laura Ellen

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

7. Birth date of deceased May 6 1870 (Month) (Day) (Year)

8. AGE: Years 74 Months 9 Days 27 If less than one day hr. min.

9. Birthplace Union Co, Ill (City, town, or county) (State or foreign country)

10. Usual occupation Retired Emp

11. Industry or business Nove - McCord

FATHER
12. Name Frank H. Rauch.
13. Birthplace Unk Penn (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sarah Astz
15. Birthplace Unk Penn (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Ethel Waller Wilde

(b) Address 2117 Eugene Field Avenue

17. (a) B (Burial, cremation, or removal) (b) Date thereof Nov. 5 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cem.

18. (a) Signature of funeral director Stamer Funeral Home

(b) Address St Joseph Mo

19. (a) 3/5/45 (Date received local registrar) Helen J. Peckle (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month March day 3 year 1945 hour 5:20 minute P. M.

21. I hereby certify that I attended the deceased from June 1944, 19 to March 1945, 19; that I last saw him alive on March 2 1945, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic pneumonia.	72 hrs.
Due to: arteriosclerosis.	15 yrs
Due to	
Other conditions — (Include pregnancy within 3 months of death)	

97

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. W. Ryan (M. D. or other)

Address St Joseph Mo Date signed 3.5.45

1311 (Licensed Embalmer's Statement on Reverse Side)

Dr Rijon 301 Ho 8

APR 25 1945

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 Roy Stoney

Licensed Embalmer No.....2435

P. O. Address.....St Joseph

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.