

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State-File No. _____

FILED FEB 20 1947
Registration District No. 145

Primary Registration District No. 5566

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Iron

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

(c) Name of hospital or institution:
1 mile southeast of Banner /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
life (Specify whether

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Iron **47**

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

(d) Street No. 1 mile southeast of Banner
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Linda Fay Rothlisberger

3. (b) If veteran, name war no

3. (c) Social Security No. none

20. DATE OF DEATH: Month Feb. day 5
year 1947 hour 2 minute 20 P.M.

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 Feb. 14 1946
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 28 1947 to Feb 5 1947;
that I last saw her alive on Feb 2 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia Duration 3 days

8. AGE: Years 0 Months 11 Days 21 If less than one day
hr. _____ min. _____

Due to 3rd degree burn

Due to Scarby

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

10. Usual occupation none

11. Industry or business _____

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

Major findings: Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

MOTHER FATHER { 12. Name Daniel Rothlisberger

{ 13. Birthplace Reynolds County Missouri
(City, town, or county) (State or foreign country)

{ 14. Maiden name Nancy Bland

{ 15. Birthplace Shannon County Missouri
(City, town, or county) (State or foreign country)

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

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

(b) Date of occurrence 4/1

(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? _____

16. (a) Informant Daniel Rothlisberger

(b) Address Banner Missouri

17. (a) burial (b) Date thereof 2-6-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Caledonia Mo.

While at work? (Specify type of place) _____ (e) Means of injury 0

23. Signature F. W. Gale (M. D. or other) _____

Address Bismarck Mo Date signed 2/6/47

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

(b) Address R. White Ironton Missouri

19. (a) Feb 10 1947 (b) Mrs Elizabeth Logan
(Date received local registrar) (Registrar's signature)

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

RECEIVED

Health Officer No. 4

or File Number 247-222

Date Filed 2-19-47

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 Wm J White.....

Licensed Embalmer No. 3012.....

P. O. Address Winton Hill.....

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Iron
(b) City or town Russell
(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

3. (a) PRINT FULL NAME Linda Rothlisberger

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

4. Sex 7 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 (Month) _____ (Day) _____ (Year) _____

8. AGE: Years _____ Months _____ Days _____ (If less than one day, hr. _____ min. _____)

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

10. Usual occupation _____

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) _____

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

15. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (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) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb year 1947 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. Immediate cause of death _____

Pneumonia Duration 7 DYS

Due to 3rd. Burns 10 DYS

Due to Scalding

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

Major findings: Of operations None

Of autopsy 14/15

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 F.H. Galt (M. D. or other) _____

Address Bermsworth Mo Date signed 2/13/47

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

SUPPLEMENTARY

S-4693