

FILED NOV 19 1947

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

Registration District No. \_\_\_\_\_ Primary Registration District No. 5305 Registrar's No. 6

1. PLACE OF DEATH:

(a) County COLE  
(b) City or town RURAL LIBERTY TOWNSHIP  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
R. R # 3 JEFFERSON CITY, MO.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community LIFE  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County COLE 26  
(c) City or town RURAL LIBERTY TOWNSHIP  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. R. R # 3 JEFFERSON CITY  
(If rural, give location)  
(e) Citizen of foreign country? NO 0 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCTOBER day 28  
year 1947 hour 11 minute 35 P.M.

21. I hereby certify that I attended the deceased from Jan 4, 1947 to Oct 25, 1947  
that I last saw him alive on Oct 25, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage  
Due to hypertensive cardiac vascular disease  
Duration 3 days

Other conditions Carcinoma of breast  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 15  
ADDITIONAL PHYSICIAN SUPPLEMENTARY INFORMATION REQUESTED

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 0

23. Signature Dean Taylor (M. D. or other) MD  
Address Jefferson City Date signed 10-31-47

3. (a) PRINT FULL NAME CAROLINE RACKERS

3. (b) If veteran, name was NO 3. (c) Social Security No. NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife HENRY RACKERS 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased DECEMBER 22, 1867  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
79 10 10 hr. \_\_\_\_\_ min.

9. Birthplace WARDSVILLE, MO. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

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

12. Name HERMAN HENRY ROLING 4

13. Birthplace GERMANY 4  
(City, town, or county) (State or foreign country)

14. Maiden name GERTRUDE KIES

15. Birthplace GERMANY 4  
(City, town, or county) (State or foreign country)

16. (a) Informant LOUIS RACKERS

(b) Address JEFFERSON CITY, MO.

17. (a) BURIAL (b) Date thereof 10/31/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation TAGS MO.

(a) Signature of funeral director Sylvester Dulle

(b) Address JEFFERSON CITY, MO.

19. (a) 10-31-47 (b) R. G. Davis MD  
(Date received local Registrar) (Registrar's signature)

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

MOTHER FATHER

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed NOV 18 1947

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.....

*Melvin L. Janssens*....., Registered Apprentice No. *489*  
working under my personal supervision.

Signed..... *Sylvester Dulle*.....

Licensed Embalmer No. *4321*

P. O. Address..... *Jefferson City, Mo*

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. Dec  
Registrar's No. 6

Registration District No. 77

Primary Registration District No. 5305

1. PLACE OF DEATH:

(a) County cole

(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)

3. (a) PRINT FULL NAME Caroline Rocher

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 wid

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

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

7. Birth date of deceased Dec 22 1947  
(Month) (Day) (Year)

8. AGE: Years 79 Months 10 Days 10  
(If less than 24 hr. \_\_\_\_\_ min.)

9. Birthplace mo  
(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 \_\_\_\_\_  
(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)

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 \_\_\_\_\_  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 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 Carcinoma of colon Duration \_\_\_\_\_

Due to Primary site  
transverse colon

Due to \_\_\_\_\_

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

Major findings: Of operations H&E

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 James A. Taylor (M. D. or other) MD  
Address Jefferson City Mo Date signed 11-25-47

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

SUPPLEMENTARY

Leen Taylor M.D.

city

37511