

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26458

State File No. _____

LED AUG 30 1951

BIRTH NO. _____		REG. DIST. NO. <u>77</u>		PRIMARY REG. DIST. NO. <u>3016</u>		Registrar's No. <u>214</u>		
1. PLACE OF DEATH a. COUNTY <u>COLE</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>JEFFERSON CITY</u> c. LENGTH OF STAY (in this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION <u>CHAS. E. STILL DOSTEOPATHIC HOSP</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>FRANKLIN</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>NEW HAVEN - RURAL 0360</u> d. STREET ADDRESS (If rural, give location) <u>R.F.D. # 1</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>RICHARD</u> b. (Middle) <u>EDWARD</u> c. (Last) <u>ROHIFING</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>AUG. 16 1951</u>		5. SEX <u>MALE</u>			
6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>		8. DATE OF BIRTH <u>DEC. 29, 1948</u>		9. AGE (In years last birthday) <u>8</u> If under 1 year: Months <u>7</u> Days <u>17</u> If under 24 hrs: Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>R.F.D.#1 NEW HAVEN, MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>GILBERT HENRY ROHIFING</u>			13b. MOTHER'S MAIDEN NAME <u>MILDRED BAUMGARTNER</u>		14. NAME OF HUSBAND OR WIFE <u>NEVER MARRIED</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>X Gilbert H Rohifing</u> ADDRESS <u>NEW HAVEN</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Circulatory Collapse</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Pulmonary Embolism</u> DUE TO (c) <u>General peritonitis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u>
19a. DATE OF OPERATION <u>8/15/51</u>		19b. MAJOR FINDINGS OF OPERATION <u>Ruptured Appendix</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____						
22. I hereby certify that I attended the deceased from <u>8/15</u> , 19 <u>51</u> , to <u>8/16</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>8/16/51</u> , 19 <u>51</u> , and that death occurred at <u>7:35 PM</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>R. H. Michael M.D.</u>				23b. ADDRESS <u>Jefferson City Mo</u>		23c. DATE SIGNED <u>8/16/51</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>8/18/51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>SEANATE GROVE</u>		24d. LOCATION (City, town, or county) (State) <u>Rt #1 New Haven Mo.</u>		
DATE REC'D BY LOCAL REG. <u>Aug 16-1951</u>		REGISTRAR'S SIGNATURE <u>R. P. Darris MD</u>		FEDERAL DIRECTOR'S SIGNATURE <u>Charles Blum</u> ADDRESS <u>Berger Mo</u>				

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED 8-29-51

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 8-29-51

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Gustav W. Victorle

Licensed Embalmer No. 4329

P. O. Address St. Louis 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.