N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County: Iron

Township: ~~Arcadia~~ or Village: or City: Pilot Knob (NO. ____, ____ St.; ____ Ward)

Registration District No. 392 File No. 31363

Primary Registration District No. 4231 Registered No. 22

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Henry Reuchhausen

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	Married

DATE OF BIRTH: July (Month) 12 (Day), 1831 (Year)

AGE: 80 yrs. 2 mos. 10 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): Employed Saw mill

BIRTHPLACE (City or town, State or foreign country): Hanover, Germany

PARENTS
NAME OF FATHER: Henry Reuchhausen
BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany
MAIDEN NAME OF MOTHER: Don't Know
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A E Westermann

(ADDRESS) Edgehill Mo

Filed Sept. 25, 1911 John S. Luthy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: September (Month) 22 (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 1, 1911, to Sep 22, 1911, that I last saw him alive on Sept 16, 1911, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

General debility

(Duration) ____ yrs. ____ mos. 21 ds.

Contributory (SECONDARY): dysentery

(Duration) ____ yrs. ____ mos. 21 ds.

(Signed) G W. Farrar M. D.

Sep 23, 1911 (Address) Ironton Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bruce Mo	Sept. 24, 1911
UNDERTAKER: John Albert	ADDRESS: Ironton Mo

MISSOURI STATE BOARD OF HEA
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Revised United States Standard Certificate of Death

PLACE OF DEATH

County Iron

Township 6 Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____ _____ St.: _____ Ward)

[If death occur hospital or ins give its NAME of street and nu

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____, 1_____
(Month) (Day) (Year)

AGE _____yrs. _____mos. _____ds.

If LESS than 1 day, _____hrs. or _____min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____,
(Month) (Day)

I HEREBY CERTIFY, that I attended decease
_____, 191____, to _____,
that I last saw h_____ alive on _____,
and that death occurred, on the date stated above, at _____
The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____(Duration)_____yrs._____mos.

Contributory _____
(SECONDARY)
_____(Duration)_____yrs._____mos.

(Signed) _____

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Ca (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN RECENT RESIDENTS)

At place of death _____yrs._____mos._____ds. In the State _____yrs._____mos.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL | DATE OF BUR

UNDERTAKER | ADDRESS

Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless im- death).