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MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **31567**  
Registrar's No. **245**

Registration District No. **104**

Primary Registration District No. **3008**

1. PLACE OF DEATH:  
(a) County **Callaway**  
(b) City or town **Julton**  
(c) Name of hospital or institution: **State Hospital no 1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **45 days**  
In this community **45 days**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County **Scotland**  
(c) City or town **Memphis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **0**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Henry C. Rosenberger**  
(b) If veteran, name war \_\_\_\_\_  
(c) Social Security No. **None**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Sept** day **23**  
year **1940** hour **7** minute **P.** M.

4. Sex **male** 5. Color or race **white**  
6. (a) Single, widowed, married, divorced **married**  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Aug 20 1872**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Sept 1**  
\_\_\_\_\_, 19**40**, to **Sept 23**, 19**40**;  
that I last saw h\_\_\_\_\_ alive on **Sept 23**, 19**40**;  
and that death occurred on the date and hour stated above.

8. AGE: Years **68** Months **1** Days **3**  
If less than one day  
hr. \_\_\_\_\_ min.

Immediate cause of death **Cerebral Hemorrhage** Duration \_\_\_\_\_  
Due to **arterio sclerosis + Huntington's Chorea**

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

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

10. Usual occupation **Harness maker**

MOTHER FATHER { 11. Industry or business \_\_\_\_\_  
12. Name **Bartholmeu Rosenberger**  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name **Unknown**  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant **Maud Rosenberger**  
(b) Address **Carroll Iowa**

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

17. (a) **Partial Removal** (b) Date thereof **Sept 26-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Memphis Mo**

(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? \_\_\_\_\_

18. (a) Signature of funeral director **R. N. Crews**  
(b) Address **Memphis Mo**  
(c) Date received local registrar **Sept. 23, 1940** (d) **R. N. Crews** (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_  
23. Signature **James Thomas** (M. D. or other) \_\_\_\_\_  
Address **State Hospital no 1** Date signed **9/23-40**

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

**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 *P. B. Payne*

Licensed Embalmer No. 2196

P. O. Address Memphis

**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.**