

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 28 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11466
State File No. _____
Registrar's No. 2416

Registration District No. 318 Primary Registration District No. 1003

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 weeks (Specify whether years, months or days)

3. (a) PRINT FULL NAME CASPER ROHRBACHER
3. (b) If veteran, name war No 3. (c) Social Security No. _____

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced widowed
6. (b) Name of husband or wife Wilhelmina 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased August 13th, 1860
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 6 23 hr. min.

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

10. Usual occupation retired

11. Industry or business _____

MOTHER FATHER { 12. Name Jacob Rohrbacher
13. Birthplace Paris France
(City, town, or county) (State or foreign country)

{ 14. Maiden name Magdelaine Fischer
15. Birthplace Alsace Lorraine France
(City, town, or county) (State or foreign country)

16. (a) Informant Rose Fritz
(b) Address 6116 Elizabeth, St. Louis, Mo.

17. (a) burial (b) Date thereof Mar. 10, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olive Cemetery

18. (a) Signature of funeral director Hacker-Kelch & Co.
(b) Address 3634 Gravois, St. Louis, Mo.

19. (a) MAR 8 1947 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 317
(If outside city or town limits, write "RURAL")
(d) Street No. 6116 Elizabeth Memorial (If rural, give location) 9
(e) Citizen of foreign country? No (Yes or No) 0
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 6th
year 1947 hour 11:20 minute P M.
21. I hereby certify that I attended the deceased from _____, 19____ to 3/6/47, 19____;
that I last saw him alive on 3/6/47, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Broncho pneumonia
Due to _____
Due to 107
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy _____
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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury _____
23. Signature W. W. Fitzgerald (M. D. embalmers)
Address 1515 Lafayette 3/8/47
Embalmer's name _____

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.....

Frank J. Ireland

Licensed Embalmer No.....

2675

P. O. Address.....

St. Louis

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.