

FILED MAR 23 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11427

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

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 37 PRIMARY REG. DIST. NO. 3070 Registrar's No. 6661

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WEBSTER GROVES RYRS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WEBSTER GROVES, MO</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) <u>409 BAKER AVE</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>409 BAKER AVE</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>IDA</u> b. (Middle) <u>MATILDA</u> c. (Last) <u>ROTHLISBERGER</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>MCH 14-1950</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>FEB 13-1881</u>	9. AGE (in years last birthday) <u>69</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>ST JOSEPH MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>BERNHARDT FRIEDE</u>		13b. MOTHER'S MAIDEN NAME <u>WILHELMINA SEIFERT</u>		14. NAME OF HUSBAND OR WIFE <u>JOHN ROTHLISBERGER</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. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs E J Johnson - 409 Baker W. Mo</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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Several months</u>
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Chronic Myocarditis</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c) _____			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____			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 3/9, 1950, to 3/14, 1950, that I last saw the deceased alive on 2/25, 1950, and that death occurred at 2 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Hugh Haynes M.D.</u> (Degree or title)		23b. ADDRESS <u>3720 Washington Ave</u>		23c. DATE SIGNED <u>3/14/50</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>3-14-1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u>		24d. LOCATION (City, town, or county) (State) <u>ST JOSEPH MO</u>	
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DATE REC'D BY LOCAL REG. <u>3-14-50</u>		REGISTRAR'S SIGNATURE <u>Herbert J. Donke</u>		FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Parker and Co - Webster Groves Mo</u>	
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WRITE PLAINLY—USING UNFADEING 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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Leslie Welch*

Licensed Embalmer No. *4395*

P. O. Address *Walter Groves*

**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.