

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

10360

State File No. _____

BIRTH NO. **FILED MAR 31 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2611**

1. PLACE OF DEATH a. COUNTY ST. LOUIS		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ILLINOIS b. COUNTY SAGINAW	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY OR TOWN ILLIOPOLIS	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 22 days		e. STREET ADDRESS (If rural, give location) Box 156	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CHILDREN'S HOSPITAL			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) JAN	b. (Middle) DARRYL	c. (Last) RAUTBORT	(Month) 3	(Day) 20	(Year) 1954
5. SEX 0	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH 1-8-1951	9. AGE (In years last birthday) 3	10. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (City and State or Foreign Country) DECATUR, ILLINOIS	

13a. FATHER'S NAME HENRY RAUTBORT	13b. MOTHER'S MAIDEN NAME ABRAMSON	14. NAME OF HUSBAND OR WIFE —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. —	17. INFORMANT'S SIGNATURE OR NAME S. Kingfisher ST. LOUIS CHILDREN'S HOSPITAL

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, asthma, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tubercinia ovate		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? 2044

22. I hereby certify that I attended the deceased from 2:26, 1954, to 3:20, 1954, that I last saw the deceased alive on 3-20, 1954, and that death occurred at 1:00 a.m., from the causes and on the date stated above.

23a. SIGNATURE Wm. J. Kingfisher MD.	23b. ADDRESS 500 South Kingshighway	23c. DATE SIGNED 3-20-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3-20-54	24c. NAME OF CEMETERY OR CREMATORY Agud Achim Cemetery
24d. LOCATION (City, town, or county) (State) Milwaukee, Wisconsin		

DATE REC'D BY LOCAL REG. MAR 22 1954	REGISTRAR'S SIGNATURE J. C. Smith MD.	25. FUNERAL DIRECTOR'S SIGNATURE Mayer Funeral Home	ADDRESS 4356 Lindell Blvd
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48

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.....
Signature of Student Embalmer

Signed *J W M Bumbley*.....
Licensed Embalmer No. *365*
P. O. Address *H Leub*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.