

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004611

STATE FILE NUMBER 239

FILED MAR 9 1959

Registration District No. 042

Primary Registration District No. 1000

Registrar's No.

300  
7-57

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1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b> <i>0117</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Jackson Rest Home</b>		Length of stay in lb <b>35 years</b>	d. STREET ADDRESS (If outside, give location) <b>518 N. 3rd St.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>REXROTH</b> Last <b>REXROTH</b>			4. DATE OF DEATH <b>March 2, 1959</b> Month <b>March</b> Day <b>2</b> Year <b>1959</b>		
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 22, 1870</b>	9. AGE (In years last birthday) <b>89</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. MAJOR OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	11. BIRTHPLACE (City and state or country) <b>Wilton Junction, Iowa</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Lawrence Rexroth</b>	13b. MOTHER'S MAIDEN NAME <b>unknown</b>	14. NAME OF HUSBAND OR WIFE <b>_____</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT <b>Mrs. Rose Fuller, 2828 Lafayette, St. Joseph, Mo.</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
DUE TO (b) <b>General Arteriosclerosis</b>		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>331X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <b>1/6/58</b> to <b>3/2/59</b> and last saw <sup>her</sup> / <sub>him</sub> alive on <b>3/2/59</b> Death occurred at <b>9:00a.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>S. E. Meluney M.D.</b>	22b. ADDRESS <b>Social Welfare Board 10th &amp; Olive, St. Joseph, Mo.</b>	22c. DATE SIGNED <b>3/3/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>3/3/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Joseph Missouri</b>
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24. FUNERAL DIRECTOR <b>Walter Bowman</b>	ADDRESS <b>St. Joseph, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>Mar. 6, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Walter Clark Standell</b>
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Eugene Wood* .....

Licensed Embalmer No. *3804* .....  
P. O. Address *319 S 10th St* .....

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.