

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031657

FILED VS SEP 23 1959

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 247

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>CALLAWAY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>MORGAN</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>FULTON</b>		Length of stay in 1b <b>8 yrs.</b>	c. CITY OR TOWN <b>VERSAILES</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>STATE HOSPITAL NO. 1</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>UNKNOWN</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>RAUSCHELBACH</b> Last			4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-29-1878</b>	9. AGE (last birthday) <b>80</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (City and state or country) <b>MORGAN COUNTY, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>LEO RAUSCHELBACH</b>		13b. MOTHER'S MAIDEN NAME <b>ELLEN LEGG</b>		14. NAME OF HUSBAND OR WIFE <b>ANNA B. RAUSCHELBACH</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT Address <b>STATE HOSPITAL NO. 1, FULTON, MO.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Bronchitis and</u>		
DUE TO (c) <u>Bronchiectasis</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary Tuberculosis, Coronary insuff.</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)	
20c. TIME OF INJURY Hour Month, Day, Year 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 <b>St. Hosp</b>	COUNTY <b>Callaway</b>	STATE <b>Mo</b>
21. X <del> was</del> attended the deceased from <b>1-25-1951</b> to <b>9-18-59</b> and last seen <b>XXXXXX</b> Death occurred at <b>4:20 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>James K. Otterbein M.D.</u>		22b. ADDRESS <u>State Hospital No. 1</u>		22c. DATE SIGNED <u>9-18-59</u>
23a. BURIAL, CREMATION, OR MOVABLE (Specify) <u>BURIAL</u>	23b. DATE <u>20 Sept 59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HOPEWELL CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>MORGAN County, Mo</u>	
24. FUNERAL DIRECTOR <u>KIDWELL FUNERAL HOME - VERSAILES, MO</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>Sept 18-1959</u>	26. REGISTRAR'S SIGNATURE <u>Maretta Lawrence</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SEP 30 1959

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.