

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-012596

STATE FILE NUMBER

Registration District No. 251 Primary Registration District No. _____ Registrar's No. 69

DO NOT WRITE ON THIS STUB
AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

FILED MAR 25 1963	
1. PLACE OF DEATH	
a. COUNTY <u>Nodaway</u>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clearmont</u>	a. STATE <u>Mo.</u> b. COUNTY <u>Nodaway</u>
Length of stay in 1b <u>3 years</u>	c. CITY OR TOWN <u>Maryville</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wallin Nursing Home</u>	d. STREET ADDRESS (if outside, give location) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED	
First <u>Carrie</u> Middle <u>Ethel</u> Last <u>Rauch</u>	4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>63</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1,7,1878</u>
9. AGE (last birthday) <u>85</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>home-own</u>
11. BIRTHPLACE (City and state or country) <u>Parnell, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>John A. Stutesman</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Chamberlain</u>
14. NAME OF HUSBAND OR WIFE <u>George W Rauch</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 Address <u>Ora Rauch, Maryville, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line)	
PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) <u>Myocardial Failure</u>	INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Secondary Anemia</u>
DUE TO (c) <u>Cerebral vascular accident</u>	<u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerosis & Senility</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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 _____
21. I attended the deceased from <u>Dec 15, 1962</u> to <u>Mar 13, 1963</u> and last saw her alive on <u>3/13/63</u> Death occurred at <u>7:21</u> a <u>m</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>Robert A. Muschman M.D.</u> (Degree or title)	22b. ADDRESS <u>Box 388 Clearmont, Mo.</u>
22c. DATE SIGNED <u>3/13/63</u>	22d. LOCATION (City, town, or county) <u>Parnell Mo</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>3,16,1963</u>
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City, town, or county) <u>Parnell Mo</u>
24. FUNERAL DIRECTOR <u>Achison Funeral Home, Maryville, Mo.</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>3-16-63</u>
26. REGISTRAR'S SIGNATURE <u>Bess Lovell</u>	

(Licensed Embalmer's Statement on Reverse Side)

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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 *E M Ottis*

Licensed Embalmer No. 2279

P. O. Address *Marysville, Mo*

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.