

FILED MAY 4 1942
Registration District No. 5-5-2

Primary Registration District No. 5-5-2

State File No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town North of town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Ed. Rau, residence
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community From Dec 21, 1941 (Specify whether
years, months or days)

3. (a) PRINT FULL NAME William Rau

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Deceased 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 14 1854
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>87</u>	<u>6</u>	<u>24</u>	hr. _____ min. _____

9. Birthplace Moniteau Co. Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business _____

12. Name Frank Rau

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Annie Marie Schmidt

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Edward Rau

(b) Address Buckner, Missouri

17. (a) Burial (b) Date thereof Mar 12, 1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cedron Cemetery

18. (a) Signature of funeral director L. J. Menister

(b) Address Buckner, Mo

19. (a) 1161 W. M. Reppert
(Date received local Registrar's) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper
(c) City or town Baconville
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes for No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 16
year 1942 hour 3.25 minute _____ P. M.

21. I hereby certify that I attended the deceased from Feb, 1942
1942 to Mar 10 1942
that I last saw him alive on March 10 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia Duration 24 hrs

Due to Myocardial Degeneration 2 mos
(To my knowledge)

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) While at work? _____ Means of injury _____

23. Signature W. H. Higgins (M. D. or other) Do

Address Buckner Mo Date signed 3/10/42

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

MOTHER FATHER

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.....
....., Registered Apprentice No.
working under my personal supervision.

Signed C. L. Julian

Licensed Embalmer No. 1399

P. O. Address Higbee

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.

STANDARD CERTIFICATE OF DEATH

State File No. 145-61

Registration District No.

Primary Registration District No. 4233

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Buckner
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 yr
(Specify whether years, months or days)

3. (a) PRINT FULL NAME William Rau
3. (b) If veteran, name war. — 3. (c) Social Security No. —

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced —

6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive — years

7. Birth date of deceased Aug - 14 - 1885
(Month) (Day) (Year)

8. AGE: Years 87 Months 6 Days 20
If less than one day (hr) (min)

9. Birthplace Mo
(City, town, or county) (State or foreign country)

10. Usual occupation —

11. Industry of business —

12. Name —

13. Birthplace Mo
(City, town, or county) (State or foreign country)

14. Maiden name —
(City, town, or county) (State or foreign country)

15. Birthplace Mo
(City, town, or county) (State or foreign country)

16. (a) Informant —

(b) Address —

17. (a) — (b) Date thereof —
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation —

18. (a) Signature of funeral director —

(b) Address —

19. (a) — (b) —
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cooper
(c) City or town Boonville
(If outside city or town limits, write "RURAL")
(d) Street No. —
(If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10
year 1942 hour 3 minute 35 P. M.

21. I hereby certify that I attended the deceased from — to — 1942;
that I last saw him — alive on — 1942;
and that death occurred on the date and hour stated above.

Immediate cause of death hypostatic pneumonia
toxic
Due to —

Due to myocardial degeneration

Other conditions —
(Include pregnancy within 3 months of death)

Major findings: 108
Of operations —

Of autopsy —

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) —

(b) Date of occurrence —

(c) Where did injury occur? —
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
—

While at work? — (Specify type of place) (c) Means of injury —

23. Signature — (M. D. or other) —

Address — Date signed —

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

