DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

25953

State File No.

AUG 6 1943

Registration District No. 316

Primary Registration District No. 6075

Registrar's No. 294

1. PLACE OF DEATH:
(a) County St. Francois
(b) City or town Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mo. State Hospital No 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8yrs. 2 mos. 9 dys.
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Ferguson
(If outside city or town limits, write "RURAL")
(d) Street No. Route 10, Box 463
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME CLAUDE E. ROUSE

3. (b) If veteran, name war Unknown

3. (c) Social Security No. None

4. Sex Male

5. Color or race W.

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Theresa Booth

6. (c) Age of husband or wife if alive Age Unk years

7. Birth date of deceased August (Month) 23, (Day) 1899 (Year)

8. AGE: Years	Months	Days	If less than one day
43	10	3	hr. min.

9. Birthplace St. Louis, (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Banker, filling station, and

11. Industry or business W. P. A. worker.

MOTHER FATHER

12. Name Charles S. Rouse

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

14. Maiden name Myrtle E. Kelley

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

16. (a) Informant Records State Hospital No. 4
(b) Address Farmington, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-1943 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Lebanon Cem., St. Louis Co., Mo.

18. (a) Signature of funeral director Geo. L. Pleitsch, Inc.
(b) Address 5966-68 Easton Ave., St. Louis, Mo

19. (a) July 9-1943 (Date received by local registrar) (b) Byrdie Bohrmeister (Registrar's signature)

1140 (Licensed Embalmer's Statement on Reverse Side) Farmington

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26, year 1943 hour 5 minute 40 P. M.

21. I hereby certify that I attended the deceased from April 1, 1943, 19..., to June 26, 1943, 19...; that I last saw him/her alive on June 26, 1943, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Embolism	
Due to Recent hip fracture	
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) 094
(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? (e) Means of injury 0

23. Signature J. C. Langsam (M. D. or other) Md
Address 408 W. Front St. Date signed 6/28/43

SEP 9 1943

RECEIVED

District Health Officer No. 4

District File Number 843 - 2

Date Filed 8 - 5 - 4

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 Lemara W. Traeger

Licensed Embalmer No. 2678

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. AUG 5 1943

Registration District No. 316 Primary Registration District No. 6075 Registrar's No. 294

1. PLACE OF DEATH

(a) County St Francois

(b) City or town Rural St Francois Twp
(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 (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(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

3. (a) PRINT FULL NAME Claude E Rouse

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug (Month) 23 (Day) 1899 (Year)

8. AGE: Years 43 | Months 10 | Days | If less than one day min.

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

10. Usual occupation

11. Industry or business

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day 26 year 1943 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Embolism — Duration

Due to Recent hip fracture — 5 yr

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations 1806 18

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) Accident fell on ward

(b) Date of occurrence 5-5-43

(c) Where did injury occur? Hab Hosp No 4 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Pt stumbled & fell walking on ward (Specify type of place)

While at work? No (e) Means of injury fell

23. Signature J G Langham (M. D. or other)

Address 408 N Knight Date signed 8-11-43
Farmington, Mo.

SUPPLEMENTARY

S-25953