DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Washington State Department of Health

VITAL STATISTICS
CERTIFICATE OF DEATH

State File No. 187
Registrar's No. 128

1. PLACE OF DEATH:
(a) County Whatcom
(b) City or town Rural (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: (Smith Rd.) Route 1, B'ham, Wn. (If not in hospital or institution write street number or location)
(d) Length of stay: In hospital or institution ____ In this community (Years, months or days) (Specify whether) 59 yr's

2. USUAL RESIDENCE OF DECEASED:
(a) State Washington (b) County Whatcom
(c) City or town Rural (If outside city or town limits, write RURAL)
(d) Street No. Route 1, Bellingham (If rural give location)
(e) If foreign born, how long in U. S. A.? 59 years

3. (a) FULL NAME Fredrick Rauch
3. (b) Was decedent ever a member of the Army, Navy or Marine Corps of the United States? ____ Name of organization in which such service was rendered: ____ Rank ____ Period of service ____
3. (c) Social Security Number none

4. Sex: male
5. Color or race: white
6(a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Kate Rauch
6(c) Age of husband or wife if alive ____ years
7. Birth date of deceased: June (Month) 25, (Day) 1871 (Year)
8. AGE: Years 75 | Months 1 | Days 20 | If less than one day ____ hr. ____ min.
9. Birthplace: unknown (City, town or county) Germany (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business: (illegible)
Father 12. Name: unknown
Father 13. Birthplace: Germany (City, town, or county) Germany (State or foreign country)
Mother 14. Maiden name: unknown
Mother 15. Birthplace: unknown (City, town, or county) Germany (State or foreign country)
16. (a) Informant's own signature: Mrs. Sophie Faut
(b) Address: 1819 "F" St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/19/46 (Month) (Day) (Year)
(c) Place: burial or cremation: Bayview
18. (a) Signature of funeral director: John W. Wright
(b) Address: 1831 Cornwall Ave
19. (a) AUG 27 1946 (Date received local registrar) (b) ____ (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month August day 15
year 1946 hour ____ minute ____
21. I hereby certify that I attended the deceased from ____, 19__, to ____, 19__;
that I last saw him alive on 7-30, 1946;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral apoplexy	
Due to: Arteriosclerosis (c)	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Diabetes Mellitus	

Major findings:
Of operations: none
Of autopsy: none

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? ____ (e) Means of injury ____

23. Signature: [illegible] (M. D. or other)
Address [illegible] Date signed 8/26/46