

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1114 Madison Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME William Bernard Rocklage

3. (b) If veteran, name war _____

3. (c) Social Security No. 489-10-4751

4. Sex Male

5. Color or race White

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

6. (b) Name of ~~husband~~ or wife Susie Rocklage

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

7. Birth date of deceased April 1, 1874
(Month) (Day) (Year)

8. AGE: Years 65 Months 6 Days 25
If less than one day _____ hr. _____ min.

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

10. Usual occupation Tobacco Worker

11. Industry or business Liggett + Meyers Tob Co.

MOTHER FATHER { 12. Name Frank Rocklage

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

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

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

16. (a) Informant's own signature Mr. Leo Krupp

(b) Address 6419 Devonshire Ave

17. (a) Burial (b) Date thereof Oct 27 '39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cem.

18. (a) Signature of funeral director Wagner-Von-Froh

(b) Address 3402 No. Kingshighway

19. (a) Oct 26 1939 (b) J. F. Budich
(Date of registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 26
(If outside city or town limits, write "RURAL")
(d) Street No. 1114 Madison Street
(If rural, give location)
NO PHYSICIAN IN ATTENDANCE
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 25th
year 1939 hour 11:10 minute A. M.

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

Immediate cause of death _____
Chronic Myocarditis;
Chronic Interstitial Nephritis;

Due to _____

Due to _____

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

Major findings: _____
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)
Means of injury _____

23. Signature Joseph M. L... (M. D. or other) 4

Address Deputy Coroner Date signed _____

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

Albert W. Hoop

Licensed Embalmer No. *1861*

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 this body is not embalmed, above space should be left blank.

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