S. No. 2
M—1-4-41
v. 5-17-39
I X28390

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

FILED JUN 6 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 18983

Registration District No. 784 Primary Registration District No. 200 Registrar's No. 1126

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Kirk Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 days (Specify whether
In this community 25 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 100
(c) City or town St. Louis 17 (If outside city or town limits, write "RURAL")
(d) Street No. 1919 a Franklin Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ISADORE RODGERS
3. (b) If veteran, name war No
3. (c) Social Security No. 486-18-6230
4. Sex M
5. Color or race N
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife Isabelle Rogers
6. (c) Age of husband or wife if alive 40 years
7. Birth date of deceased Feb (Month) 15 (Day) 1896 (Year)

8. AGE: Years	Months	Days	If less than one day
45	2	10	hr. min.

9. Birthplace Memphis (City, town, or county) Tenn. (State or foreign country)
10. Usual occupation Laborer
11. Industry or business N. P. A.
FATHER 12. Name William Rodgers
13. Birthplace Unknown (City, town, or county) ? (State or foreign country)
MOTHER 14. Maiden name Julia
15. Birthplace Unknown (City, town, or county) ? (State or foreign country)
16. (a) Informant Hospital Records
(b) Address Robert Koch Hosp.
17. (a) (Burial, cremation, removal) (b) Date thereof 5-26-41 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove St. Charles
18. (a) Signature of funeral director Metropolitan
(b) Address 2025 Dickerson
19. (a) MAY 28 1941 (Date received local registrar) (b) L. R. Murphy M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25 year 1941 hour 7 minute 35 A.M.
21. I hereby certify that I attended the deceased from March 11, 1941, to May 25 1941 that I last saw him alive on May 25 1941 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Meningitis (Tuberculous)	2 hrs
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Pulmonary Tuberculosis	14 mo.

Major findings:
Of operations
Of autopsy Culs. Tb. and Meningitis Tuberculous

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 Herbert C. Sweet (M. D. or other) M
Address Robert Koch Hosp. Date signed 5/25/41

(Licensed Embalmer's Statement on Reverse Side)

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 Chas. L. Howell

Licensed Embalmer No. 2452

P. O. Address 2820 Dickson

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.