

FILED NOV 30 1944 318

State File No. \_\_\_\_\_  
Registrar's No. 9782

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:  
City Infirmary  
(If not in hospital or institution, write street number or location) D  
(d) Length of stay: In hospital or institution 21 days (Specify whether  
In this community life years, months or days)

3. (a) PRINT FULL NAME Mary S. Rogan  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widow  
6. (b) Name of husband or wife Martin T. 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug. 18, 1857  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
87 3 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Louis Granneman  
13. Birthplace Germany (City, town, or county) (State or foreign country) G  
14. Maiden name unknown  
15. Birthplace unknown (City, town, or county) (State or foreign country) G

16. (a) Informant C. Hannon  
(b) Address 5800 Arsenal St.

17. (a) BURIAL (b) Date thereof 11 18 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEMETERY  
FEETZ BROS

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address 3029 LAFAYETTE

19. (a) NOV 19 1944 (Date received local registrar) J. F. Braseck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
Missouri  
(a) State \_\_\_\_\_ (b) County St. Louis  
(c) City or town St. Louis (If outside city or town limits, write "RURAL")  
(d) Street No. 747 Yale, University, City, Mo. (If rural, give location)  
(e) Citizen of foreign country? American (Yes or No) 0  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 16  
year 1944 hour 2:15 P.M. minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from Oct. 26, 1944  
to Nov. 16, 1944

that I last saw her alive on Nov. 16, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Senility (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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Dr. Maxwell (M. D. or other) \_\_\_\_\_  
Address 5800 Arsenal Date signed 11-16

**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 *Francis J. Owens*

Licensed Embalmer No. *7245*

P. O. Address *St. Louis Mo*

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

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

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Dec  
Registrar's No. 9782

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town St. Louis  
(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 \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Mary S. Rogan

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased Aug 18  
(Month) (Day) (Year)

8. AGE: Years 87 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 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) \_\_\_\_\_ (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) DEC (b) J. J. Bredeck  
(Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day \_\_\_\_\_  
year 19 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

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) (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTAL

1944

S-36345