

FILED JUL 16 1945

Registration District No. _____ Primary Registration District No. **3066**
~~6076~~

Registrar's No. **1762**

1. PLACE OF DEATH:

(a) County St. Louis County

(b) City or town Kirkwood
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: U.S. Marine Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 years & 8 days
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME MARGARET RODGERS

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 Married /

6. (b) Name of husband or wife M.S. Rodgers / 6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased April 8 1911
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>34</u>	<u>3</u>	<u>2</u>	— hr. — min.

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

10. Usual occupation PHS Nurse

11. Industry or business _____

12. Name Clarence Kane

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

14. Maiden name Margaret Boyle

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

16. (a) Informant Dr. Maurice S. Rodgers

(b) Address Marine Hosp. Kirkwood 27 Mo.

17. (a) Removal (b) Date thereof July 11 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cleveland, Ohio

18. (a) Signature of funeral director Mittelberg Funeral Home

(b) Address Webster Street 19 Mo.

19. (a) 7-13-45 (b) E. J. M. Saran M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County (St. Louis City) **000**

(c) City or town St. Louis **149**
(If outside city or town limits, write "RURAL.")

(d) Street No. 5528 Pershing Ave.
(If rural, give location) **1,**

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10
year 1945 hour 12:00 minute midnight

21. I hereby certify that I attended the deceased from July 2, 1943 to July 10, 1945
that I last saw her alive on July 10, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis, pulmonary, bilateral, chronic, acute
Duration 5 years & 8 mo.

Due to _____

Due to **136**

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) (e) Means of injury _____

23. Signature J. Kelly P.A. Surgeon
J. Kelly (M.D. or other) (R)
Address US Marine Hosp, Kirkwood USPHS Date signed 7-11-45

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

96
4
3

JUL 19 1945

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.....

John M. Meyer

Licensed Embalmer No. *3288*

P. O. Address.....

*340 W. Adams Ave.
St. Louis 27, Missouri*

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.