S. No. 2
M—1/47
v. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32957

FILED OCT 4 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8954

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 5551 St. Louis Ave.
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 510

(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")

(d) Street No. 5551 St. Louis Avenue, 9
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Bernard A. Rolfes

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex male 0

5. Color or race white

6. (a) Single, widowed, married divorced single C

6. (b) Name of husband or wife ---

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

7. Birth date of deceased April 27th 1877
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
70	4	27	hr. min.

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

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name Henry Rolfes 4
13. Birthplace Germany
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Adelaide Lodiecke
15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Adelaide Rolfes-Sister
(b) Address 5551 St. Louis Ave.,

17. (a) burial (b) Date thereof 9-26-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Int. St.Peter&Paul Cem.

18. (a) Signature of funeral director Sullivan Undertakers,
(b) Address 2849 North Euclid Avenue,

19. (a) SEP 25 1947 (b) J. F. Biedeck
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 24th
year 1947 hour 1 A.M. minute M.

21. I hereby certify that I attended the deceased from Sept 23-d, 1946, to Sept 23-d, 1947, that I last saw h. alive on Sept 23-d, 1947, and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Chronic myocarditis

Due to Chronic bronchitis of senility

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause of 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 W. Jackson Miller (M. D. or other)

Address 4622 Nat Bridge Date signed Sept 24 1947

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

Dr. W. Jackson Miller
4032 Natural Bridge
Ne. 2277

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 Robert L. Brinkman
Licensed Embalmer No. 3553
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, fact should be so stated above.