

FILED MAY 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14103**
3541
Registrar's No.

BIRTH NO. **49-011042** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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|--|--|--|--|--|----|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. LENGTH OF STAY (in this place) 3 months | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | 17 |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Route 6 HOMER G. PHILLIPS HOSPITAL | | | d. STREET ADDRESS (If rural, give location) 10 MARION | | |

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|---|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) RITA b. (Middle) c. (Last) ROGERS | | | 4. DATE OF DEATH (Month) (Day) (Year) APRIL 15 1949 | | |
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|-------------------------|----------------------------------|--|---|---|-------------------------------------|-----------------------------------|
| 5. SEX FEMALE | 6. COLOR OR RACE NEGRO | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 1 | 8. DATE OF BIRTH JAN. 28 1949 | 9. AGE (In years last birthday) 3 | 10 UNDER 1 YEAR Months 12 | 11 OVER 12 Mths. Hours Min. |
|-------------------------|----------------------------------|--|---|---|-------------------------------------|-----------------------------------|

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|--|--|-----------------------------------|--|---|--|------------------------------|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) St. Louis Mo. | | 12. CITIZEN OF WHAT COUNTRY? | |
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|---|--|---|--|-----------------------------|--|
| 13a. FATHER'S NAME HENRY ROGERS | | 13b. MOTHER'S MAIDEN NAME DELIA LEMON | | 14. NAME OF HUSBAND OR WIFE | |
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|---|--|--|--|--|--|------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | 17. INFORMANT'S SIGNATURE OR NAME DELIA ROGERS | | | ADDRESS 210 MARION |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhagic Pseudomonas meningitis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Congenital Cardiac DUE TO (c) Hypertrophy | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | | | |

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| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 157 | |
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|---|--|--|--|--|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 77244 | |
|---|--|--|--|--|--|

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **10:00 P.M.** m., from the causes and on the date stated above.

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|---|--|-----------------------------------|--|------------------------------------|--|
| 23a. SIGNATURE (Degree or title) Joseph M. Quinn M.D. | | 23b. ADDRESS 1300 Clair | | 23c. DATE SIGNED 4/20/49 | |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24b. DATE 4/20/49 | 24c. NAME OF CEMETERY OR CREMATORY WASHINGTON-PARK | 24d. LOCATION (City, town, or county) (State) MISSOURI | | |
|--|-----------------------------|--|--|--|--|

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| DATE REC'D BY LOCAL REG. APR 20 1949 | | REGISTRAR'S SIGNATURE J. B. Lancaster | | 25. FUNERAL DIRECTOR'S SIGNATURE R. H. Burks | | ADDRESS 212 CARROLL | |
|--|--|---|--|--|--|-------------------------------|--|

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed *Wendell J. Yandell*

Licensed Embalmer No. *4243*

P. O. Address *143 Magnolia St*

Webster Grove, Mo

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.