

FILED MAY 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH17169
Stat. File No. 4349

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS</u>		c. LENGTH OF STAY (in this place) <u>28 YRS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>10 North Kingshighway</u>				d. STREET ADDRESS (If rural, give location) <u>10 N. KINGSHIGHWAY</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>RUTH</u> b. (Middle) <u>ROGERS</u> c. (Last) <u>COMPTON</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 14 1949</u>						
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>DEC 27-1880</u>		9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 YEAR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>SYRACUSE NEBRASKA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13a. FATHER'S NAME <u>JOSIAH ROGERS</u>			13b. MOTHER'S MAIDEN NAME <u>MARY BRYANT</u>		14. NAME OF HUSBAND OR WIFE <u>CHARLES H COMPTON</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Charles H. Compton</u> ADDRESS <u>St Louis MO</u>					
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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocarditis, Ch</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>Influenza</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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) <u>St Louis MO</u>					
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? <u>1st</u>					
22. I hereby certify that I attended the deceased from <u>May 1934</u> , to <u>May 14, 1949</u> , that I last saw the deceased alive on <u>May 14, 1949</u> , and that death occurred at <u>6:00</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <u>H N Oberhelman</u> (Degree or title) <u>M.D.</u>			23b. ADDRESS <u>3903 Olive</u>			23c. DATE SIGNED <u>5/16/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>5-17-1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>OAK HILL CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>KIRKWOOD MO</u>				
DATE REC'D BY LOCAL REG. <u>MAY 16 1949</u>		REGISTRAR'S SIGNATURE <u>J B Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Parker and Co. Webster Groves Mo</u> ADDRESS _____					

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Leslie Welch

Signed _____

Student Embalmer

Licensed Embalmer No. _____

4395

P. O. Address _____

Walter Groves

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.