

FILED AUG 13 1949

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **25226**
6776

318

1003

Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis				c. CITY (If outside corporate limits, write RURAL and give township) St. Louis			
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital				d. STREET ADDRESS (If rural, give location) 26 2410a Blair Ave.			
3. NAME OF DECEASED (Type or Print)		a. (First) Ronald		b. (Middle) E		c. (Last) Rogers	
4. DATE OF DEATH		(Month) 8		(Day) 35		(Year) 49	
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH Nov. 5th. 1943	
9. AGE (In years last birthday) 5		IF UNDER 1 YEAR Months		IF UNDER 1 YEAR Days		IF UNDER 1 HRS. Hours Min.	
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 Missouri		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME George Rogers			13b. MOTHER'S MAIDEN NAME Pauline Allen			14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS George Rogers 2410a Blair Ave.			
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) Pneumonia Terminal ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Upper respiratory infection DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 3 days	
19a. DATE OF OPERATION 8/3/49		19b. MAJOR FINDINGS OF OPERATION Obstruction of trachea				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (STATE) 100		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 517X					
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 5 A.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) L. B. Pasater				23b. ADDRESS		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-6-1949		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Bloomfield Mo	
DATE RECD BY LOCAL REG. AUG 4 1949		REGISTRAR'S SIGNATURE J. B. Pasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hy. Leidner U, 2223 St. Louis Ave.			

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

X mch 10 1949

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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.

Student

Student Embalmer

Signed *J. Allen Davis*

Licensed Embalmer No. *4053*

P. O. Address *4355 Washington*

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.