No. 300
10-48

FILED MAR 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11011

State File No. 2346

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St.Louis
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION: Enroute City Hospital

2. USUAL RESIDENCE (Where deceased lived.) If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St.Louis
d. STREET ADDRESS (If rural, give location): 446 N. Sarah St.

2199
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3. NAME OF DECEASED (Type or Print)
a. (First): Florence
b. (Middle): R.
c. (Last): Rogers

4. DATE OF DEATH (Month) (Day) (Year): March 9, 1950

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow

8. DATE OF BIRTH: Aug.25,1900

9. AGE (In years last birthday): 49
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): St.Liborius,Nebraska

12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Frank Faye

13b. MOTHER'S MAIDEN NAME: Mary Manion

14. NAME OF HUSBAND OR WIFE: Dexter L.Rogers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT'S SIGNATURE OR NAME ADDRESS: William Frey, 446 N. Sarah St.

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Lobar Pneumonia

DUE TO (c) Embolism of brain

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

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): 4341

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

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* 9:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Patrick E. Taylor Jr. Coroner

23b. ADDRESS: 1300 Clark

23c. DATE SIGNED: 3/10/50

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: 3-10-50

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State): Lusk,Wyoming.

DATE REC'D BY LOCAL REG.: MAR 10 1950

REGISTRAR'S SIGNATURE: J. B. Sander

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Albert H.Hoppe,4700 Washington Blvd.

(Licensed Embalmer's Statement on Reverse Side)

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

2346

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.....

.....

working under my personal supervision.

Student Embalmer No.....

Signed Robert M Murray

Signed.....
Student Embalmer

Licensed Embalmer No. 3749

P. O. Address St. Louis, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.