

FILED OCT 18 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

34927

State File No. _____

BIRTH NO. _____ REG. DIST. **318** PRIMARY-REG. DIST. NO. **1003** Registrar's No. **8221**

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) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (In this place)		2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 3437 Lawton	

3. NAME OF DECEASED (Type or Print) Bessie	a. (First)	b. (Middle)	c. (Last) Hobbs	4. DATE OF DEATH (Month) (Day) (Year) 9 25 50
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5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Jan 14, 1908	9. AGE (In years last birthday) 42	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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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) Mississippi	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Chamers Rogers	13b. MOTHER'S MAIDEN NAME Minnie Bland	14. NAME OF HUSBAND OR WIFE Wilbert Rogers West Helena Ark.
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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.	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Wilbert Rogers Helena Ark.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Guillain-Barré syndrome		
	ANTECEDENT CAUSES DUE TO (b) Anemia Hypochromic DUE TO (c) Undetermined		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Decubitus, Buttuks & Thighs			

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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 241X
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22. I hereby certify that I attended the deceased from **9-23-** 19**50**, to **9-25-** 19**50**, that I last saw the deceased alive on **9-25-** 19**50**, and that death occurred at **1:55 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE Foreuzo Harris	(Degree or title) M. D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/30/50	24c. NAME OF CEMETERY OR CREMATORY Oak Dale	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE REC'D BY LOCAL REG. 9/29/50	REGISTRAR'S SIGNATURE J. P. ...	25. FUNERAL DIRECTOR'S SIGNATURE F.A. Green	ADDRESS 4214 Delmar Blvd.
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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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

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.