

FILED NOV 30 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38183

1920

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

BIRTH NO. _____ REG. DIST. NO. 205 PRIMARY REG. DIST. NO. 6077 Registrar's No. 40

1. PLACE OF DEATH a. COUNTY St Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St Charles	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Charles		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Charles	
c. LENGTH OF STAY (in this place) 20 yrs		d. STREET ADDRESS (If rural, give location) 1210 Olive St	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Paul Mo Rt #1		4. DATE OF DEATH (Month) (Day) (Year) Oct. 16 1950	
3. NAME OF DECEASED (Type or Print) a. (First) Hugo		b. (Middle) L	
c. (Last) Rohlfing		5. SEX M	
6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED* (Specify) Widowed	
8. DATE OF BIRTH Sept 4 1886		9. AGE (In years last birthday) 64	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Contractor	
11. BIRTHPLACE (State or foreign country) Berger Mo		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Gustav Rohlfing		13b. MOTHER'S MAIDEN NAME Emma Duffner	
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) No	
16. SOCIAL SECURITY NO. 497-07-8688		17. INFORMANT'S SIGNATURE OR NAME Monroe Rohlfing ADDRESS St Louis Mo.	
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) coronary artery thrombosis & atherosclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) generalized arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4201	
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) (STATE)	
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?		22. I hereby certify that I attended the deceased from Jan 1, 1950 , to Oct 16, 1950 , that I last saw the deceased alive on Oct 15, 1950 , and that death occurred at 4 P m., from the causes and on the date stated above.	
23a. SIGNATURE George E. Paster (Degree or title) MD		23b. ADDRESS St Charles Mo	
23c. DATE SIGNED 10-19-50		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE Oct. 20 1950		24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	
24d. LOCATION (City, town, or county) (State) St Charles Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Stachman, Paul ADDRESS St Charles Mo.	
DATE REC'D BY LOCAL REG. 11-8-50		REGISTRAR'S SIGNATURE Monroe Rohlfing	

(Licensed Embalmer's Statement on Reverse Side)

File No. 17
DISTRICT HEALTH OFFICE No. 4

NOV 17 1950

RECEIVED

MAR 26 1953

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 Arthur C. Bane

Signed _____

Student Embalmer

Licensed Embalmer No. 3144

P. O. Address St Charles

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.