

FILED JUL 2 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21165**
Registrar's No. **5526**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE **MO** b. COUNTY **2219**

b. CITY OR TOWN **St Louis 3** c. LENGTH OF STAY (in this place) _____

c. CITY OR TOWN **St Louis** d. Is Residence within limits of a city or incorporated town? Yes No **0**

d. FULL NAME OF HOSPITAL OR INSTITUTION **in Room to Home** e. STREET ADDRESS (If rural, give location) **21 3025 Delmar St**

3. NAME OF DECEASED (Type or Print)
a. (First) **Andrew** b. (Middle) **Rogers** c. (Last) _____

4. DATE OF DEATH (Month) (Day) (Year)
6 19 54

5. SEX **Male** 6. COLOR OR RACE **C**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Widowed

8. DATE OF BIRTH **May 10 1895**

9. AGE (In years last birthday) **59** 10. UNDER 1 YEAR Months _____ Days _____ 11. UNDER 1 HRS. Hours _____ Min. _____

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

10b. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTH PLACE (City and State or Foreign Country)
Ark

12. CITIZEN OF WHAT COUNTRY?
USA

13a. FATHER'S NAME **Unknown**

13b. MOTHER'S MAIDEN NAME **Unknown**

14. NAME OF HUSBAND OR WIFE **Unknown**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes #1

16. SOCIAL SECURITY NO. _____

17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS
Marie Strayhorn 4612 Wisconsin

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____
ANTECEDENT CAUSES
Myocardial Insufficiency
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.
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)
422, 2

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

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 _____, m., from the causes and on the date stated above.

23. SIGNATURE **Joseph M. Decker** (Type or Print) (Degree or title) _____

23b. ADDRESS **1300 Clark**

23c. DATE SIGNED **6/21/54**

24. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

24b. DATE **6-23-54**

24c. NAME OF CEMETERY OR CREMATORY **National City**

24d. LOCATION (City, town, or county) (State)
Jefferson Parish MO

DATE RECD'Y LOCAL REG. **JUN 21 1954**

REGISTRAR'S SIGNATURE **J. Earl Smith, M.D.**

25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS
W. H. Burgo 3506 Franklin

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. .

Student.....
Signature of Student Embalmer

Signed *Leroy H. Fannin*.....

Licensed Embalmer No. *452*

P. O. Address *3880 E...*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.