

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32516

State File No.

FILED SEP 28 1954

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>546</u>		Registrar's No. <u>2184</u>		
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____				
b. CITY OR TOWN <u>Overland</u>		c. LENGTH OF STAY (In this place) <u>3 1/2 weeks</u>		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Rugh Manor Rest Home</u> <u>3326 Eminence Ave.</u>				e. STREET ADDRESS (If rural, give location) <u>4550a Fair Ave.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>ELIZABETH</u> b. (Middle) _____ c. (Last) <u>ROHLFING</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 14, 1954.</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, DIVORCED (Spouse) <u>Widowed</u>		8. DATE OF BIRTH <u>Dec. 21, 1874.</u>		
9. AGE (In years last birthday) <u>79</u>		f UNDER 1 YEAR Months _____ Days _____		f UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Carl Schatz</u>			13b. MOTHER'S MAIDEN NAME <u>Wilhelmina Burkhardt</u>			14. NAME OF HUSBAND OR WIFE <u>Frank Rohlfing</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mr. Wm. Dillon, 4550a Fair Ave.</u> ADDRESS _____			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES DUE TO (b) <u>Arteriosclerosis</u> <u>Cardio-Vascular Dis.</u> DUE TO (c) <u>Chr. Arthritis</u> II. OTHER SIGNIFICANT CONDITIONS <u>Osteitis deformans</u> <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>					INTERVAL BETWEEN ONSET AND DEATH <u>6 Weeks</u> <u>25 y. 0</u>	
19a. DATE OF OPERATION <u>Sept. Aug. 53</u>		19b. MAJOR FINDINGS OF OPERATION <u>3 transvaginal Hernia (Pigeon's Dis)</u>					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) _____ m.		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 <u>Mich. 1928</u> to <u>Sept. 14, 1954</u> , that I last saw the deceased alive on <u>Sept. 13, 1954</u> , and that death occurred at <u>6:05A</u> m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Walter C. Kuchner M.D.</u>				23b. ADDRESS <u>508 N. Grand Blvd.</u>		23c. DATE SIGNED <u>9/14/54</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9/17/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Zion Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>		
DATE REC'D BY LOCAL REF. <u>9/15/54</u>		REGISTRAR'S SIGNATURE <u>Hebe A. Sombert</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Malvin F. Feutz, 4828 Natural Bridge Blvd.</u> ADDRESS _____ (Licensed Embalmer) (Statement on Reverse Side)				

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

4

No. 300
10-48

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 *John A. Minar*

Licensed Embalmer No. *418*

P. O. Address *St. Louis*

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.