

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUL 20 1956

25232  
STATE FILE NUMBER  
6400

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

|   |                                  |   |  |  |   |
|---|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St. Louis</u>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> |  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <u>St. Louis</u>  |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN <u>St. Louis 2189</u>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>St. Louis City Hosp</u>   |                                  | Length of stay in lb<br><u>3 days</u>   | 18 STREET ADDRESS <u>1309 So. Vandeventer</u> (If outside, give location)  |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Lucille</u> Middle <u>Rogers</u> Last <u>Rogers</u>  |                                  |   | 4. DATE OF DEATH<br>Month <u>7</u> Day <u>6</u> Year <u>1956</u>   |  |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>3/19/1916</u>   | 9. AGE (In years last birthday)<br><u>40</u><br>IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u><br>IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u> |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>at home</u>   |  | 11. BIRTHPLACE (City and state or country)<br><u>Missouri</u>  |   |
| 10c. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |                                  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |   |
| 13. FATHER'S NAME<br><u>Edw. Lauer</u>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><u>Cath. Lorentz</u>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>unknown</u>   |  | 17. INFORMANT<br><u>Medical Records - St. Louis City Hosp</u><br>Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pending Autopsy Report</u><br><u>Suspected Miliary Pulmonary tuberculosis with bacterial septic shock</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Miliary (Autopsy report confirms diagnosis of Pulmonary Tub.)</u> |                                  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>.002x</u>                                 |  |   |
| 20c. TIME OF INJURY<br>Hour _____ a. m. _____ p. m.<br>Month, Day, Year _____   |                                  |   | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)  |  |   |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                  |   | 20f. CITY, TOWN, OR LOCATION COUNTY STATE  |  |   |
| 21. I attended the deceased from <u>7/7/56</u> to <u>7/6/56</u> and last saw <u>her</u> alive on <u>7/6/56</u><br>Death occurred at <u>11:10 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.   |                                  |   |  |  |   |
| 22a. SIGNATURE<br><u>Stuart A. Yaffe, M.D.</u> (Degree or title)  |                                  |   | 22b. ADDRESS<br><u>St. Louis City Hospital</u>   |  | 22c. DATE SIGNED<br><u>7/7/56</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>removal</u>   |                                  | 23b. DATE<br><u>7-9-56</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Weldon Springs, Mo.</u>   |  | 23d. LOCATION (City, town, or county) (State)<br><u>Weldon Springs, Mo.</u>           |
| 24. FUNERAL DIRECTOR<br><u>Rowland-Aker, 4104 Manchester</u> ADDRESS  |                                  |   | 25. DATE RECD. BY LOCAL REG.<br><u>JUL 9 1956</u>  |  | 26. REGISTRAR'S SIGNATURE<br><u>Carl Smith MD</u><br><u>m 83</u>                      |

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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 *W E Morris*.....

Licensed Embalmer No. *33*.....

P. O. Address *St Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (It 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.