

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
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

FILED MAR 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11363

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 476

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 <u>St. Louis</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>University City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>University City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>7252a Amhurst Avenue</u>			Length of stay in <u>13 yrs.</u>	d. STREET ADDRESS <u>7252a Amhurst Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>LYDIA</u> <u>EDNA</u> <u>ROGAN</u>			4. DATE OF DEATH <u>February 19th, 1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan'y 2, 1893.</u>	9. AGE (In years last birthday) <u>64.</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife..</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home.</u>	11. BIRTHPLACE (City and state or country) <u>Brooklyn, New York.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Garrison.</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Moore.</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no.</u>		16. SOCIAL SECURITY NO. <u>none.</u>	17. INFORMANT Address <u>John E. Rogan, #7252a Amhurst Ave.,</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>achalasia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>stat.</u> <u>years</u>
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.) <u>332X</u>			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>8/24/55</u> to <u>Feb. 19, 1957</u> and last saw <u>him</u> alive on <u>Feb 8, 1957</u> Death occurred at <u>5:30 p.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Robert D. Smith M.D.</u>		22b. ADDRESS <u>114 NORTH TAYLOR AVE</u>		22c. DATE SIGNED <u>FEB. 20-1957</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial..</u>		23b. DATE <u>Feb'y 22/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery.</u>		23d. LOCATION (City, town, or county) (State) <u>#7800 St. Charles Rock Road.</u>
24. FUNERAL DIRECTOR <u>C.R. LUPTON & SONS</u>		ADDRESS <u>7233 DELMAR BLVD.</u>		25. DATE RECD. BY LOCAL REG. <u>2/21/57</u>	26. REGISTRAR'S SIGNATURE <u>Herbert B. Donahoe</u>

Dr. Robert Smith
114 North Taylor
Jefferson 3-8600

Hours 10:00 To 12:00

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 Clarence A. Murray

Licensed Embalmer No. 4011

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.