

FILED MAY - 8 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15209

State File No.

3867

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY		
b. CITY OR TOWN St. LOUIS		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 <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 1936th COLE ST			e. STREET ADDRESS (If rural, give location) 2170 1936th COLE ST.		
3. NAME OF DECEASED (Type or Print) a. (First) LIZZIE		b. (Middle)	c. (Last) RODGERS		4. DATE OF DEATH (Month) (Day) (Year) APRIL 20 1957
5. SEX F	6. COLOR OR RACE C	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH UNKOWN	9. AGE (In years, last birthday) abt. 62	If UNDER 1 YEAR: Months _____ Days _____ If UNDER 4 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and State or Foreign Country) VALLEY PARK MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A
13a. FATHER'S NAME ELIJAH WYNN		13b. MOTHER'S MAIDEN NAME SARAH ?		14. NAME OF HUSBAND OR WIFE HENRY RODGERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Hattie Martin 1936th Cole		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		<p><i>Caloric selected</i></p> <p><i>Heart Disease</i></p> <p><i>Art. Sclerosis</i></p>			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			
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 420.0			20. AUTOPSY? YES <input checked="" 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.

23a. SIGNATURE <i>[Signature]</i>		23b. ADDRESS 1300 Clair	23c. DATE SIGNED 4/23/57
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24a. BURIAL, CREMATION, REMOVAL REMOVAL	24b. DATE 4-26-57	24c. NAME OF CEMETERY OR CREMATORY GREENWOOD Cem	24d. LOCATION (City, town, or county) (State) St. LOUIS CITY MO
DATE REC'D BY LOCAL REG. APR 23 '57	REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A. J. Walton 2707 Stoddard	

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.....
W. Claude Gordon

Licensed Embalmer No. *3489*

P. O. Address *4575 Al*

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.