

Health, Welfare, Public Service

300  
1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED OCT 11 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER  
34059  
9000

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

|  |  |   |                               |
|--|--|---|-------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE MISSOURI b. COUNTY ST LOUIS |                               |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN ST LOUIS                  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | c. CITY OR TOWN OVERLAND MO   |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION DEACONESS HOSPITAL |  | Length of stay in lb 4 WEEKS  | d. STREET ADDRESS 2314 WISMER |

|  |                           |   |  |  |  |
|--|---------------------------|---|--|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>OTTO WILLIAM ROHLFING                                |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>9-25-57                      |  |  |
| 5. SEX<br>MALE   | 6. COLOR OR RACE<br>WHITE | 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>2-6-1885                                       |  | 9. AGE (In years (to birthday))<br>72  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>CARPENTER         |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>RETIRED  | 11. BIRTHPLACE (City and state or country)<br>STONEY HILL MISSOURI |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |
| 13. FATHER'S NAME<br>CHRISTIAN ROHLFING  |                           |   | 14. MOTHER'S MAIDEN NAME<br>LOUISA BARNER                          |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br>NO |                           | 16. SOCIAL SECURITY NO.<br>484-05-3671  | 17. INFORMANT<br>Address<br>OLGA ROHLFING 2314 S WISMER            |  |  |

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 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) Generalized carcinomatosis  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>6 mons.   |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.   |  | DUE TO (b) Adenocarcinoma of the prostate  |  | 1 yr.   |  |
|  |  | DUE TO (c)   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>Arteriosclerotic heart disease- 2 years                              |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 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.) |  |   |  |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a. m. p. m.  |  |  |  |   |  |
| 20d. INJURY OCCURRED<br>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 10/17/56 to 9/25/57 and last saw her alive on 9/25/57<br>Death occurred at 4:35 P. m on the date stated above; and to the best of my knowledge, from the causes stated. |  |  |  |   |  |
| 22a. SIGNATURE<br><i>J. J. Galt MD</i>   |  | (Degree or title)  |  | 22b. ADDRESS<br>835 Mo. Theatre Bldg., 3  |  |
| 22c. DATE SIGNED<br>9/26/57  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  |  | 23b. DATE<br>9-28-57   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>MOUNT LEBANON   |  |
|  |  |  |  | 23d. LOCATION (City, town, or county) (State)<br>ST ANN MISSOURI                                  |  |
| 24. FUNERAL DIRECTOR<br>EARL HILLEMANN OVERLAND MO   |  | ADDRESS<br>SEP 26 57   |  | 25. DATE RECD. BY LOCAL REG.<br>26. REGISTRAR'S SIGNATURE<br>J. Carl Smith, MD                    |  |

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.....  
*Ead J. Hellenman*

Licensed Embalmer No. *350*

P. O. Address *Orland*

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