

XC 442648 SL 15387

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42528

STATE FILE NUMBER

FILED DEC 13 1957

318

Registration District No.

1003

Registrar's No. 11774

S. 300
ev. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N.GRAND, ST. LOUIS, MO.		c. CITY OR TOWN METROPOLIS	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION V.A. HOSPITAL		d. STREET (If outside, give location) ADDRESS SPENCE APT-B	
3. NAME OF DECEASED (Type or print) First Middle Last MARION F. ROGERS		4. DATE OF DEATH Month Day Year 12-6-57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-6-86
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	11. BIRTHPLACE (City and state or country) UNIONVILLE, TENN.
13a. FATHER'S NAME JOHN F. ROGERS		13b. MOTHER'S MAIDEN NAME MARY R. OSTEN	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address VA HOSP. RECORDS, ST. LOUIS, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) GAS GANGRENE, LEFT ABOVE KNEE AMPUTATION STUMP, POSTOPERATIVE ARTERIOSCLEROSIS OBLITERANS Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH APP. 16 HOURS UNKNOWN
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 Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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 11/19/57 to 12/6/57 and last saw him alive on 12/6/57 Death occurred at 5:15 A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Embalmers title) H. F. Westphalinger		22b. ADDRESS VAH, 915 N.GRAND, ST. LOUIS, MO.	22c. DATE SIGNED 12/6/57
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 12/6/57	23c. NAME OF CEMETERY OR CREMATORY Brookport, Ill	23d. LOCATION (City, town, or county) (State) Brookport, Ill.
24. FUNERAL DIRECTOR Edward Fendler 5611 South Grand Blvd.		25. DATE RECD. BY LOCAL REG. DEC 9 57	26. REGISTRAR'S SIGNATURE Carl Smith mo in JB

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

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 *Harley F. Faella Jr*
Licensed Embalmer No. *4950*
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.