

FILED DEC 20 1957

STANDARD CERTIFICATE OF DEATH

46265
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **12030**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) 23 INSTITUTION St. John's Hospital			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 4317A Tholozan		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carol Lee Rogers			First	Middle	Last	4. DATE OF DEATH Month Dec Day 14 Year 1957		
5. SEX Female	6. COLOR OR RACE Wht.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-12-57		9. AGE (In years last birthday)	IF UNDER 1 YEAR Months 2 Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Arthur Rogers				14. MOTHER'S MAIDEN NAME Marian Werner				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Arthur Rogers 4317a Tholozan				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) atelectasis, congenital bilateral DUE TO (b) Immature prematurity DUE TO (c) 2nd Twin PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) 2nd° twin at 32 wks							INTERVAL BETWEEN ONSET AND DEATH 7625.	
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 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 12-12-57 to 12-14-57 and last saw ^{her} him alive on 12-13-57 Death occurred at 3:10 P. M. m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE Vincent L. Eberle, M.D.				22b. ADDRESS 4952 Maryland		22c. DATE SIGNED 12-14-57		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)		
burial	12/16/1957	SS Peter & Paul Cem.		St. Louis, Mo.				
24. FUNERAL DIRECTOR ADDRESS J L Ziegenhein & Sons 7027 Gravois				25. DATE RECD. BY LOCAL REG. DEC 16 '57		26. REGISTRAR'S SIGNATURE Carl Smith MO		

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 No Embalming, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed E. P. Kidwell

Licensed Embalmer No. 387

P. O. Address 7027 Ave

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.