

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023687
STATE FILE NUMBER

FILED JUN 27 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

6240

300
1-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 32 ST. LUKES HOSPITAL		Length of stay in lb 2179	d. STREET ADDRESS (If outside, give location) 4151 Shaw Blvd Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last LAURA PODLIVNER ROGERS.			4. DATE OF DEATH Month Day Year June 17, 1958		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1895	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Worker; Sup. Visor		10b. KIND OF BUSINESS OR INDUSTRY Home Maker	11. BIRTHPLACE (City and state or country) Russia 6	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Boris Podlivner.	13b. MOTHER'S MAIDEN NAME Zelda unk	14. NAME OF HUSBAND OR WIFE Joseph A. Rogers.
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or other service) No None	16. SOCIAL SECURITY NO. 498-26-6843	17. INFORMANT Mr. Joseph A. Rogers, 4151 Shaw Blvd	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral infarct with Metastases</i> DUE TO (b) <i>Acute Leukemia (Cell type indifinite)</i> DUE TO (c) <i>None</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i> <i>2 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Med Deshelets</i>		19. WAS AUTOPSY PERFORMED? 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.)
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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
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21. I attended the deceased from Death occurred at <i>6-1-58</i> to <i>6-17-58</i> and last saw her alive on <i>6-17-58</i> <i>3:30 p.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i> (Degree or title)	22b. ADDRESS <i>3720 Washington</i>	22c. DATE SIGNED <i>6/18/58</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 6-19-1958	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory	23d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri
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24. FUNERAL DIRECTOR C, R. Lupton & Sons. 7233 Delmar Blvd	25. DATE RECD. BY LOCAL REG. JUN 19 58	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

City

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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*

P. O. Address *St. Louis Mo.*

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.